Vol. XXVI. JANUARY, 1904. No. 1

THE

Southern Practitioner

AN INDEPENDENT MONTHLY JOURNAL

DEVOTED TO MEDICINE AND SURGERY.

NASHVILLE, TENNESSEE.

YEARLY SUBSCRIPTION, $1.00 A YEAR IN ADVANCE.

DEERING J. ROBERTS, M.D.,

Editor and Proprietor, 208 N. High Street, Nashville, Tenn.

Entered at the Postoffice at Nashville, Tenn., as second-class matter.

Southern Publishing Association, Printers, Nos. 1025-27 Jefferson Street, Nashville, Tenn.

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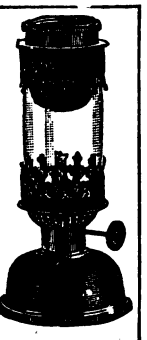

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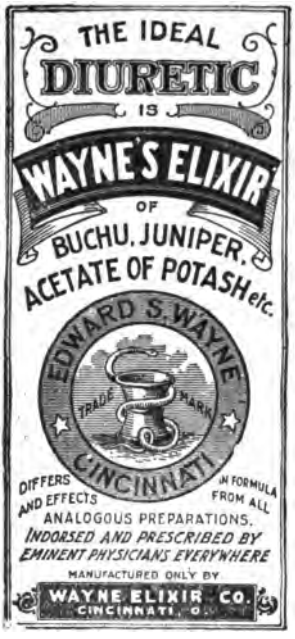

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Vol. XXVI. NASHVILLE, JANUARY, 1904. No. 1

Original Communications.

DO WE PLACE TOO HIGH A VALUE ON THE PRESENCE OR ABSENCE OF MURMURS IN CARDIAC DISEASE?*

BY E. G. WOOD, M.D.,

Professor of Practice of Medicine and Clinical Medicine in the Medical Department of the University of Nashville.

To the average medical student a cardiac murmur possesses a peculiar and fascinating interest. Entering the hospital ward, armed with his stethoscope, he rushes with undisguised satisfaction to the "new heart case" that has been admitted, and if he can discover and accurately locate a murmur, he is eminently pleased with himself and his diagnostic powers. In too many instances he entirely ignores the information to be gained by the symptoms and by inspection, palpation, and percussion, and promptly proceeds with auscul-

*Read at meeting of the Nashville Academy of Medicine, Tuesday, Dec. 1, 1903.

tation. If there is no murmur, his verdict is that all is well and there is no organic disease. If, on the other hand, a murmur is heard, the victim is at once condemned to the dangers of serious heart disease, if not to an early death. Even auscultation is incomplete, for, satisfied with the presence or absence of a murmur, he pays little or no attention to the character of the normal sounds, notwithstanding that the quality and intensity of the latter are often of much greater importance than the existence or nonexistence of the former. Too often he learns, only after long and perhaps humiliating experience, that a man may live a long and active life with no sign or symptom of disease save a blowing sound in his cardiac area; or, on the other hand, that his patient, who presented no murmur and whom he has pronounced free from organic disease, suddenly succumbs to "heart failure." After such experience he begins to question the infallibility of the one sign upon which he had placed so much reliance both in the diagnosis and prognosis of cardiac disease.

Turning now to the evidence afforded by the symptoms and by other methods of examination, he soon realizes that the information thus obtained is in many cases of far greater value than the presence or absence of a murmur, and that the true significance of the latter can be estimated only when considered in connection with the former.

The object of this paper is to show that with many of us there is still a tendency to overestimate the value of a murmur and to minimize the significance of other signs of disease in the heart; to show also that in many grave cardiac conditions a murmur may be the least valuable of all the signs present both in diagnosis and prognosis.

The relative value of murmurs to other physical signs of cardiac disease may be considered in regard to (1) diagnosis, (2) prognosis.

I. *Diagnosis. The detection of a murmur in the cardiac region is not conclusive evidence of disease of the heart.* Excluding pericardial or pleuro-pericardial friction sounds, vascular murmurs, and the murmur of aortic aneurism, murmurs in the cardiac area may be hæmic, cardio-respiratory, or organic. Hæmic and cardio-pulmonary murmurs, which are nearly always systolic, but may, as Cabot, Locke, and others have shown, be rarely diastolic,

are so common that a systolic murmur anywhere in the cardiac area must always be regarded with doubt in the absence of other signs of heart disease. If careful examination by inspection, palpation, and percussion, and attention to the character and relative intensity of the heart sounds, fail to show any sign of cardiac disease, the greatest doubt must exist as to the endocardial origin of a murmur that may be present. On this point Cabot says: "Perhaps the majority of all murmurs are unassociated with valvular disease."

Medical examiners for life insurance companies frequently meet with men whose personal history is clean, but who present systolic murmurs in the cardiac region. Interrogation fails to elicit any symptom of disease, and careful examination fails to discover any enlargement of the heart or any change in the character or intensity of its sounds. Yet, though these men swell the great army of "the rejected of life insurance companies," they often live in perfect health to a ripe old age and never show any symptom of cardiac disease. Possibly in some of these cases there is a small leak through the mitral orifice which is perfectly compensated by a vigorous and well-nourished heart, but no doubt in many of them the murmur is a cardio-respiratory one, and therefore of no serious significance.

Murmurs of endocardial origin may be produced by an incompetent or stenotic valve opening, by the passage of the current of blood over the roughened surface of the valve segments (Chauveau), or by relative obstruction at a cardiac orifice, as when the aortic ring and its valves are normal but the conus arteriosus is dilated. But a true organic murmur in itself furnishes us with very limited information, and may entirely mislead us at a time when an accurate diagnosis is important. For example, in acute articular rheumatism the detection of a murmur at the first examination naturally raises the question as to whether it is due to recent or old endocarditis, but fails to answer it. Unless it changes its character and extent from day to day, the question can be solved only by the past history and by attention to the secondary physical signs, the discovery of increased cardiac dullness with an accentuated pulmonary second sound indicating changes of some duration. It must not be forgotten that in acute rheumatism, as in other acute diseases, a functional or hæmic murmur may be heard

and disappear with recovery. Hence the presence of a murmur alone even in a case of acute articular rheumatism is not sufficient evidence of acute endocarditis.

Even in well-marked valvular lesions a murmur is only a confirmatory sign. In aortic regurgitation the collapsing pulse, the dancing arteries, with the enormously hypertrophied left ventricle and loud first sound, point almost unerringly to the incompetent aortic valves, and the diastolic murmur but confirms the diagnosis already made. In mitral regurgitation the small, weak pulse out of proportion to the rather forcible ventricular impulse at once suggests a leak, and if associated with it are increased transverse cardiac dullness, an accentuated pulmonary second sound, with dyspnœa on exertion and an enlarged liver, surely the detection of a murmur is unnecessary to a diagnosis.

A systolic murmur is frequently heard at the base of the heart, but its significance cannot be estimated in the absence of other signs. It naturally calls to one's mind aortic stenosis, but it is well known that uncomplicated stenosis at the aortic orifice is very rare, and Osler states that not over one per cent of basic systolic murmurs are due to this lesion. Such a murmur may be due to a roughened atheromatous aorta, to dilatation of the aorta, or to anæmia, or it may be cardio-respiratory. The value of this murmur by itself is therefore very limited in diagnosis.

Even when the murmur is so typical as to be characteristic of a particular lesion, as in aortic regurgitation, mitral stenosis, and in some cases of mitral regurgitation, it gives us little or no information as to the condition of the cardiac muscle and the degree of compensation, and this information, which is usually the most valuable in the case, can be obtained only by attention to the symptoms and secondary physical signs.

The absence of a murmur is not conclusive evidence that the heart is sound. In some of the gravest disorders of the heart murmurs may be absent at times or throughout the whole course of the disease.

1. Murmurs, though usually present, may at times be absent. Probably no murmur has a greater diagnostic significance than a well-marked presystolic. As long as the power of the auricular wall is good and the tension in the pulmonary veins normal, this murmur is distinct and the diagnosis clear, but when the wall of

the auricle fails, its contraction may be so feeble that the murmur becomes inaudible.

Again, in mitral regurgitation, when the wall of the left ventricle becomes so weak that the blood is not driven back through the mitral orifice with sufficient force to produce an audible sound, the murmur disappears, and if such a heart be now examined for the first time, the diagnosis must rest entirely on the other signs and symptoms. So accustomed are we to hear a mitral regurgitant murmur in mitral incompetence that, unless we realize that its absence does not negative such a lesion, we must utterly fail to recognize the true condition in such a case.

2. The absence of murmurs in grave disorders of the heart. A murmur may be absent throughout the entire course of an attack of acute endocarditis, in the malignant as well as in the simple form. It has been previously shown that the discovery of a murmur during an attack of acute rheumatism does not necessarily indicate acute endocarditis, as it may be accidental or due to an old lesion; hence the diagnosis of acute endocarditis cannot be made from the presence of a murmur alone, nor can it be excluded if no murmur be heard.

Angina pectoris is probably the most dangerous of all cardiac disorders, yet it is not directly associated with a murmur, which is, indeed, usually absent. True, a basic murmur is not infrequent, and though its presence would strengthen the diagnosis, it may be only an accidental phenomenon, and does not necessarily indicate that the anginoid attacks are the result of the condition that produces the murmur. With a history of an attack of true angina, with the characteristic sternocardiac pain and heart anguish, especially if it be associated with signs of stiff arteries, sclerosis of the aorta, dilatation of the heart, or a ringing aortic second sound, no physician would think of declaring the heart normal because no murmur could be heard. In fact, cases of true angina pectoris are occasionally met with in which no signs of cardiac or arterial disease can be discovered, and the diagnosis must rest solely on the subjective symptoms of the attack.

Another grave heart lesion in which murmurs are often absent is chronic myocarditis. Though myocardial degeneration (fatty or fibroid) is easily recognized by the pathologist, it may be entirely overlooked during life. Latent in some instances up to a fatal

termination, it may in others manifest itself in symptoms so vague and indefinite that the true nature of the malady may not even be suspected. Insomnia, with restlessness at night, nervousness, indefinite sensations in the precordial region, sighing, numbness, belching, etc., are common in chronic myocarditis, and if no murmur is heard are usually attributed to gastric disorder, or the patient is said to have a nervous heart. In more marked cases one may get a history of precordial anxiety, if not actual pain, of consciousness of the heart's action and cardiac irregularity which is usually aggravated by exertion. If such symptoms are unassociated with a murmur or signs of enlargement of the heart, they are often attributed to gastric irritability or to the abuse of tobacco or alcohol. But, though a careful examination of the heart fails to discover either murmur or increased dullness, we often find a feeble and diffuse cardiac impulse, with a weak and imperceptible apex beat. The first sound is feeble, perhaps short, closely resembling the second, and may be heard more distinctly over the right ventricle than over the left; the aortic second sound may be accentuated and the arteries may be palpable while the pulse is small and weak, perhaps irregular and intermittent. When a man past forty complains of the above symptoms, myocardial weakness should at least be suspected; and if associated with these symptoms there are a feeble apex beat and a weak first sound, myocardial change may safely be diagnosticated. In such a case "it is not so much the detection of an actual murmur that is significant as is the recognition of changes in the character and relative intensity of the cardiac sounds." (Babcock.) Balfour (Senile Heart) says: "It may be accepted as an axiom that all cardiac symptoms complained of after middle life, that cannot be distinctly referred to some evident disease, or to some affection of the cardiac mechanism due to disease, may be regarded as originating in actual or relative weakness of the myocardium."

Though relative mitral incompetence with a systolic apical murmur develops when the myocardium has given way and considerable dilatation has supervened, many cases terminate fatally before this stage is reached.

A man of fifty-six, actively engaged in business, was rather short-winded on exertion, felt an ill-defined sense of discomfort in his chest, was occasionally nauseated and weak without effort. His

face was pale, his pulse was small, compressible, irregular in force, and its weakness became more marked on elevation of the arm. Physical examination revealed no sign of cardiac disease save a feeble cardiac impulse and a weak, tapping first sound; there was no murmur. With such a history in a man of fifty-six, how much more significant were the feeble pulse and cardiac impulse, with a weak first sound, than the presence of a murmur! Though urged to take complete rest in bed, this man conducted his business as usual, and a few days later dropped dead on the street while waiting for a car.

A man of sixty-three suffered from a fairly well-marked attack of angina pectoris. After the paroxysm he was apprehensive, his pulse was weak, the cardiac dullness was increased both to the right and left, the first sound was weak and the aortic second sound accentuated; but there was no murmur. He was kept in bed, but one week later suddenly developed pain in the right chest with rapid breathing, hæmoptysis, and subnormal temperature. The heart's action was exceedingly rapid and tumultuous, and beneath the right scapula crepitant rales were heard over a small area. A few days later he died suddenly from a similar attack in which cyanosis was a marked feature. His condition was attributed to pulmonary embolism, probably due to a dislodged thrombus from the right auricle.

Both cases illustrate not only the value of the symptoms and secondary physical signs in disease of the heart, but also the occurrence of most serious cardiac lesions in which no murmur can be discovered. Doubtless many cases of myocarditis are entirely overlooked because, on a hurried and superficial examination, no murmur can be detected; yet attention to the extent of the cardiac dullness, to the pulse, and to the character and intensity of the heart sounds would lead to a prompt recognition of cardiac weakness and prevent the error of calling these cases of reflex, nervous, or tobacco hearts. One has been struck with the very superficial examination that is often made by the physician when asked if the patient can safely take an anæsthetic. He places his ear somewhere over the cardiac region, often without removing the clothing, and if he hears no murmur, at once declares that the heart is sound. It is obvious that an opinion based on such a superficial and inadequate examination is of very limited value indeed.

When a murmur is certainly of endocardial origin, it possesses a positive value in diagnosis that cannot be ignored, but unless it be considered in connection with other physical signs, its diagnostic value is decidedly limited, and if taken by itself even its endocardial origin must frequently be in doubt. As Cabot says, "No diagnosis is satisfactory which rests on the evidence of murmurs alone."

From the foregoing remarks on the diagnostic value of murmurs, it may reasonably be concluded:

1. That a murmur in the cardiac area is not conclusive evidence of disease of the heart, inasmuch as it may be hæmic or exocardial in origin.

2. That if undoubtedly endocardial in itself, it gives little or no information as to the condition of the cardiac muscle and often very little information as to the extent of the valvular lesion.

3. That in most cases changes in the size of the heart, the character and relative intensity of the cardiac sounds, and the condition of the pulmonary or peripheral circulation are the most important factors in the case.

4. That the absence of a murmur has a very limited value in excluding cardiac disease, as in many grave disorders of the heart it may be absent throughout or for a long period.

II. *The value of murmurs in prognosis.* In determining the prognosis murmurs as a rule possess very little value apart from changes in their character or intensity or the development of new ones during the progress of a case. It has been already remarked that an individual may present a murmur as the only sign of disability through a long and healthy life, and it is the experience of every physician that during an attack of acute rheumatism in early life a patient may develop endocarditis which leaves him with a permanently crippled heart as evidenced by a loud blowing murmur, but enjoy complete freedom from symptoms for many years to come. With such experience we are bound to realize that a murmur does not enable us to form an opinion as to the gravity of the case. Neither is the gravity of a valvular lesion proportionate to the intensity of the murmur. Indeed, it may be stated as a general rule, to which, however, there are many exceptions, that the louder the murmur the better the prognosis, and the fainter the sound the more gloomy the outlook. A powerful ventricle, in full compensation, may drive the blood through a narrow chink with force sufficient to cause a murmur of such intensity that it may even

be heard at some distance from the chest, while in a weak, flabby heart with a large opening, the sound produced may be so soft and low as to be heard with the greatest difficulty. If a murmur has been present and disappears coincidently with the development of decided symptoms of failing compensation, such disappearance is of grave omen, as it indicates very serious failure in muscular power, while its return under rest and the administration of cardiac tonics indicates increased power of ventricular contraction and is therefore a favorable sign. In such an instance its absence, rather than its presence, is unfavorable. It is just in such cases as these that the secondary physical signs are valuable. Increasing hepatic dullness, rales at the bases of the lungs, a diffuse cardiac impulse, with a weakening first sound and widening dullness, are signs of the gravest import.

In forming our prognosis in a given case we must rely on the general appearance of the patient, his expression, the condition of his pulmonary and peripheral circulation, the size of his heart, and the character of its sounds. Any murmur that may be present will probably supply no information of value.

In pointing out the limitations to the significance of murmurs in disease of the heart, I do not desire to underestimate their true value. I fear, however, that in the presence of a murmur in the cardiac area there is a tendency in many of us to jump to the conclusion that the patient has organic disease of the heart. It has been shown that from the presence of a murmur alone no diagnosis of cardiac disease can be satisfactory. The recognition of this fact is all-important and may prevent an unfortunate mistake, for it must be admitted that it is particularly unfortunate to tell a nervous patient that he or she has heart disease when in reality that organ is quite sound; and where there is in the mind of the practitioner a reasonable doubt as to the organic or functional origin of the murmur, it is certainly wiser to give the patient the benefit of the doubt, at least until its true character can be established.

FRACTURES OF THE SKULL.*

BY PAUL F. EVE, M.D.,
Professor of Surgery and Clinical Surgery, and Dean of the Faculty of the Medical Department of the University of Tennessee.

In presenting this brief paper to the Academy, I shall restrict my remarks to the treatment of fractures of the skull, with a report of a few cases which it has been my privilege to treat both in hospital and private practice.

It is not my purpose to enter into the diagnosis of such fractures, yet, in passing, I should like to call attention to those injuries of the head with undefined symptoms and where fractures seem probably to exist, but on account of no external wound cannot have their true character revealed. In such cases I think the surgeon is fully justified in cutting down over the seat of the injury and thoroughly informing himself of the true conditions as they exist. My reasons for this measure can readily be understood when not a few cases with conditions of this kind and where fracture did occur, coming under the observation of some surgeons, have developed epilepsy from pressure upon the brain or formed abscesses which have either been relieved later by an operation or a fatal termination occurred.

I shall commence with treatment of fractures at the vertex of the skull: First, those cases in which there is no external wound, but which by the ordinary objective and subjective signs of fracture are easily discerned. It matters not whether these fractures are lineal, cleft, or multiple, or whether they involve one or both tables, it has been my invariable rule, when not sufficiently satisfied as to such fractures, to cut down over the injury and, if found, to perform the operation of trephining. My reason for so doing is that I believe this is the only adequate measure to properly reach such troubles, and thus ward off symptoms which may subsequently present themselves. In not a few cases which have been sent to me, and where fracture has been discovered by the attending physician, epileptiform seizures have occurred, and by prompt operation for the removal of a disk for relieving this depression of the

*Read at meeting of the Nashville Academy of Medicine, Tuesday, Nov. 24, 1903

skull all such symptoms have subsided. I am aware that, not only in some works on surgery but among some eminent men in our profession, advice has been given that in some of these cases, where but little or no symptoms present themselves, the patient should be let alone and watched, and should any symptoms afterwards develop then surgical interference should occur.

I ask in this connection: Why should this be done, when it is a known fact that in many cases subsequent symptoms do frequently exist, much to the injury and discomfort of the patient, and where, under the régime of antiseptic surgery, the operation can be performed with but comparatively little danger? In compound fracture at the vault of the skull we all agree that there is but one line of treatment—namely, the elevation of the bones, or the operation of trephining. I especially desire to give emphasis to the treatment of those fractures in which the dura mater is involved, and where there is an escape of more or less brain substance. The death rate, as we know, in such injuries is very great, although not near so great as it was before the era of antiseptic surgery. The vast majority of deaths which occur in such injuries I believe are due not only to hemorrhage and shock, but also to sepsis, and consequently the greatest care and pains should be taken to thoroughly remove not only every loose bone or fragment but also every ounce of infection.

I am reminded of one of the most extensive fractures of the vault of the cranium that it has ever been my pleasure to have treated, and which occurred some eight or ten years ago, the treatment having been conducted at the City Hospital. The fracture involved a space of four and a half by three and a half inches, involving portions of the frontal, parietal, and occipital bones. The dura mater was lacerated and torn into shreds almost along the whole extent of the fracture, there was loss of brain tissue, and into the wound a considerable amount of cinders had gathered (the man having been thrown on a portion of ground covered with cinders). After combating shock, elevating the depressed portions of bones, and removing the shreds, tissues, and cinders as far as possible, I turned my attention to cleansing every portion of the wound, together with what remained of the dura mater, fully realizing that if sepsis occurred (and there was every probability of its doing so) my patient would inevitably succumb to his injury. I there-

fore determined upon heroic measures, and applied with a nail brush soapsuds, and continued to rub the part until I was satisfied that I had it perfectly clean. I next irrigated the portion of brain which had been injured by spiculæ of bones driven into it with sterilized water at a temperature of one hundred and twenty degrees, and continued this irrigation for ten or fifteen minutes. After this irrigation, a light gauze pack was placed in the wound, both for the purpose of controlling some hemorrhage which still continued and also for drainage. Although my patient was profoundly shocked and continued in this condition for twenty-four hours, I had the satisfaction of seeing him make an uninterrupted recovery, without a drop of pus appearing at any dressing.

I recall another case which has recently come under my observation, and was kindly sent me by Dr. J. W. Maddin, Sr., who treated the case in conjunction with me. A young man, twenty-four years of age, of fairly good health, had received an injury on the back of his head (at the right side) by being struck with a large piece of iron. The fracture was a compound one, the dura mater being literally torn into shreds so that it could not be detected. At the seat of the wound some brain substance had escaped, and he lost a considerable amount more during the operation. The bones were elevated, and a large spicula was found to have passed about an inch and a half into the brain substance. Upon removing this spicula, quite an excessive hemorrhage occurred; and with a view of both arresting the hemorrhage and also to remove any cause for sepsis, the wound was irrigated with a normal hot saline solution, at a temperature of one hundred and twenty degrees. The patient stood the operation fairly well, and for fourteen days no suppuration was discovered, he being allowed to return home at that time, the only symptoms developing during this time being some hallucinations, which, however, passed away, the wound giving every promise of rapid healing. Four weeks after the operation a little pus was discovered coming from the bottom of the wound, and continued to discharge every now and then for a month and a half. Thinking after this time that this was probably due to diseased bone, with his consent I performed a second operation, when, to my surprise, instead of finding any trouble at the bone, I discovered a large abscess in the brain about an inch and a half long and three-quarters of an inch wide. This abscess was evacuated and drained, and the

patient is now on a fair road to recovery. I consider this case as one of secondary, and not primary, infection. I shall burden you with a report of only two other cases before drawing my conclusions. They are as follows: The first was an engineer on the N., C., & St. Louis Ry., who, while in the discharge of his duty, happened to place his head too far out of the cab window of the engine, and was struck in the forehead by a mail crane. After his injury, he continued his run from near Kingston Springs to this city. When he arrived, he walked from the depot to my office, and when questioned, stated that he believed that he had broken some bones of his head, but did not feel any bad effects from them. The patient was removed to the infirmary for treatment, and an examination revealed a compound fracture of the frontal bone above the orbit, which led into the frontal sinus; the dura mater was lacerated, but not punctured. After elevating these depressed bones, the wound was thoroughly irrigated with a normal saline solution at a temperature of one hundred and twenty degrees, and the frontal sinus packed. Not a drop of pus was seen during any of the dressings, and the patient made an uneventful recovery.

My second case was brought to me by Dr. Goodwin, of West Nashville. He received an injury of the skull by being struck upon the left side of the head with a large lump of coal. He seemed to complain but little of his injury, and although the Doctor had detected a compound fracture of both bones of the skull, he was enabled to bring him on the street car from his home in West Nashville to my office, when he was afterwards removed to the infirmary. No symptoms of any character developed until the patient was being prepared for operation, when he was seized by several convulsions of an epileptiform character. The bones were elevated, the dura mater found intact with only a slight laceration, and a normal saline solution at a temperature of one hundred and twenty degrees was used to irrigate the wound. No symptoms of pus ever showed themselves, and the patient was enabled to be removed to his home on the twelfth day, the wound healing kindly, with a complete recovery.

From the above remarks, and also the cases cited, I draw the following conclusions:

First, that in all cases of injury to the vault of the cranium, and where suspicion of any kind would lead to a belief of fracture, or

where there is any doubt, it is the duty of every surgeon, even in cases where there is no external wound, to cut down and thoroughly investigate the seat of the injury. Should there be a small external wound, this should be enlarged and careful inspection made. If there is a fracture of the skull, whether lineal or otherwise, the operation of trephining should be performed at as early a date as possible.

Secondly, on account of the number of cases which have proved fatal from sepsis, I think a thorough irrigation with a normal saline solution should be used, this irrigation to continue from ten to twenty minutes, and where spiculæ of bone are driven into the brain tissue, this irrigation should be carried to the very bottom of such wounds.

And lastly, there should always be drainage, either by catgut, gauze, or tube; and should no pus present itself at the end of the third day, this drainage can be dispensed with. Should there be hemorrhage, it should be arrested, either by a normal saline solution at a temperature of one hundred and twenty degrees, or by a light gauze pack.

In the treatment of fractures at the base of the skull (as many of these fatalities occur from sepsis), I believe they can to some extent be prevented by a thorough irrigation with a warm normal saline solution, say at a temperature of from one hundred and fifteen to one hundred and twenty degrees. This irrigation should be placed either in the nasal cavity or the ear—the hemorrhage which occurs in such cases being at these points, where bacteria usually gain entrance. It has been my plan of treatment for some years, when I meet with such injuries, to irrigate as far into these cavities as I possibly can, and to continue this irrigation from ten to twenty minutes. After irrigating, a small gauze pack is inserted into the nasal cavity or ear, and a cotton pledget placed over this gauze, so as to keep infection from without. It is unnecessary to say that in all such cases strychnia should be administered for combating shock, and bromides with a view to place the brain as it were in a splint. The salt of bromide which I most frequently rely upon is the bromide of ammonium, as I have found better results in its administration. In some few cases I have been compelled to give opium. The form of this drug which I most rely upon, and which I believe give the least objections, is either hypodermic injection

of codeine or heroin. I place great stress upon the position of my patients, having those who have fractures at the anterior fossæ lie almost upon the abdomen, while those with fractures of the middle or posterior fossæ lie upon the ear from which the bleeding occurs. The irrigation in these cases should be done every two or three hours, and be conducted as gently as possible.

THE FINSEN LIGHT CURE.

BY H. JOHN STEWART, M.D., CHICAGO, ILL.

Having read and heard so much about the Finsen light treatment in the cure of disease, I decided in April of this year to make a personal investigation to see and learn for myself if it were true that such diseases as lupus and rodent ulcer could be cured by light. I visited several institutions where the Finsen lamp was in operation. In Manchester, England, in the Salford Skin Hospital, they had a Finsen Light Department under the supervision of Prof. Brooke, who informed me they were unable to treat half the sufferers who applied for treatment, and they had solicited by public subscription $125,000 for the erection of a new hospital for skin diseases, where they would be able to enlarge the "light department" so that at least two hundred people could be treated daily, as there were people on their waiting list whom they would be unable to treat with their present facilities for an indefinite time. Prof. Brooke was most enthusiastic over the wonderful results they were obtaining there.

I next visited the London General Hospital, of London, England, and found they were just completing an immense light department, that had been established by the present Queen of England, then Princess of Wales, in 1900, who presented the first lamp at that time, and as it was found to be far too inadequate, she had just given a second lamp, and Alfred Harmsworth had also given $50,000 for the perpetual endowment of another Finsen lamp in this department, and they were then building a platform to receive the king and queen, whom they expected to come June 1 to dedicate this new department. And even with these increased facilities, I was informed by Prof. Sequirey that there were patients on the waiting list who were unable to receive treatment.

I next visited the Light Institute at Copenhagen, and found that all the statements that had been made regarding it were not in the least exaggerated. I had the pleasure of meeting and studying under Prof. Finsen himself, and was extended every courtesy by him and his assistants at this institution. He seemed very much pleased to describe in the minutest detail the apparatus, treatment, etc., and gave me a detailed history of the lamp.

The Finsen light is a large specially constructed arc lamp of twenty thousand candle power, or twenty times stronger than an ordinary street lamp, and uses from sixty to eighty amperes of current. This lamp burns a specially made carbon, which can be procured only at Copenhagen. In the upper holder is a large carbon, while a smaller one is used in the bottom holder. When properly adjusted for arcing a maximum number of violet and ultra violet rays are produced. The advantage of the Finsen lamp over others, is in the greater number of violet rays produced. The Finsen lamp produces a much greater number of chemical rays than sunlight, as the atmosphere absorbs a large percentage of these rays. The light is so intense it is impossible to look at it with the naked eye, and it is necessary for all the attendants and patients to wear dense smoked glasses while the lamp is in operation. An aluminum hood about two feet wide surrounds the lamp, which hood is fringed on its lower border with a deep crimson-colored paper skirt to further aid in excluding the diffused light from the patients.

The concentrated rays are carried from the arc to the patients through four telescopic tubes, known as converging tubes, suspended at an angle of forty-five degrees, the tubes containing a series of rock crystal lenses so arranged that reservoirs for running water exist between them. By means of the water screen and rock crystal lenses, all rays but the violet are eliminated, and these rays are converged and concentrated, thus vastly increasing the healing and bactericidal effects.

The heat from the original arc is so intense that, to prevent cracking of the lenses and discomfort to the patients, a stream of cold water is kept constantly circulating through the reservoirs or water screens.

To further concentrate and cool the rays, a compressor is provided which consists of two rock crystal lenses so arranged that a chamber for running water exists between them. This part of the apparatus is used to compress the affected area and make it blood-

less during the treatment, thus facilitating deeper penetration. The Finsen arc light has been used with marked success in curing many skin diseases, thought until this time incurable, especially lupus and rodent ulcer. During a period of six years the Finsen Medical Light Institute at Copenhagen has grown from a very small shed, where they were able to treat only one patient at a time, to a magnificent institution where they are now treating three hundred people daily, and light institutes have been established in London, England, St. Petersburg, Russia, Paris, France, and Chicago, Ill., where they are all carrying on a similar work to the parent institution.

It has been a popular belief that lupus was a very rare disease and common only in the northern countries, and although it was supposed there was no lupus in London, the hospitals are now treating one hundred and seventy-five cases daily, and the management was compelled to install two more lamps and build a separate department, so great has been the demand from people seeking relief. Lupus was considered very rare in the United States, but since the establishment of the Finsen Light Institute in Chicago the author is informed they have been taxed to their utmost capacity, and they, too, have found it necessary to increase their facilities, as there are now patients on the waiting list who are not able to receive treatment. It seems but a question of a short time until light institutes will be established in every large city in America, because it has proven so efficacious in many other skin diseases besides lupus and rodent ulcer, such as acne, alopecia areata, localized eczema, chronic ulcers, and nævus. The treatments are given while the patients recline on couches. By firm pressure with the compressors on the tissue to be treated, the blood is removed and more heat can be borne and deeper penetration produced. This compression has another important advantage in that the bactericidal effect is greater because it has been shown that the corpuscles absorb a considerable portion of the rays, and thus prevent deep penetration.

The affected area is placed about ten inches from the distal end of the converging apparatus, and the treatments (or seances, as they are called) take about one hour daily in lupus and rodent ulcer, and in other skin diseases from ten to twenty minutes, depending upon each individual case.

The results attained have been hardly less than marvelous, since from carefully compiled statistics, covering a series of over eight hundred cases of lupus treated at the Finsen Institute, an overwhelming percentage of cures and an insignificant number of failures is shown, and Prof. Finsen goes so far as to say that in lupus vulgaris cures can be obtained in ninety-seven per cent of cases, even when the whole face is involved. In these eight hundred patients, with ages ranging from five to seventy-four years, the average duration of disease was eleven years. This treatment has an advantage over the X-ray in that there is no danger of burning and consequent sloughing. With the light treatment we are dealing with a known quantity, while with the X-ray we have an unknown quantity of uncertain action.

The light treatment causes no pain. A red erythematous spot and blister appears where the light is applied, and in five or six days the scab falls off and the ulcer is healed beneath, and the skin is left free from scar or cicatrix, but red. The redness, however, after a variable period fades and leaves the skin white and uncontracted, except where there has been a loss of tissue from the disease before treatment.

In conclusion, the author would state that the possibilities for the light treatment in the curing of disease are still unknown, and believes that in a limited time it will take an exalted position in the field of medicine and surgery.

2118 W. Lake St.

Clinical Reports.

CLINICAL SOCIETY OF THE NEW YORK POLYCLINIC MEDICAL SCHOOL AND HOSPITAL.

STATED MEETING HELD NOVEMBER 2, 1903.

The President, Dr. J. H. Burtenshaw, in the chair.

RUPTURE OF THE URETHRA.

This patient was presented by Dr. C. H. Chetwood. The boy, nine years old, fell astride the edge of a barrel. The accident was immediately followed by swelling and ecchymosis of the perineum and scrotum, which extended down the inner sides of the thighs.

On examination, the bladder could be felt slightly distended toward the brim of the pelvis. Gentle effort to introduce a soft rubber catheter was unsuccessful. The diagnosis was complete or incomplete rupture of the urethra. The patient was anæsthetized, but it was impossible to obtain entrance to the bladder through the urethra. Perineal section was then performed. The distal end of the tube was found without difficulty, but not until the perineal opening was distended with boric acid solution was it possible to distinguish and grasp the proximal end. The ends were sutured together, and a small catheter introduced through the perineal wound. Three days later the catheter was removed, and the patient urinated without trouble. Twenty-four hours later, under anæsthesia, a catheter was passed through the meatus into the bladder and tied there for three days. At the end of two weeks cure was complete.

PROSTATIC HYPERTROPHY AFTER GALVANO-PROSTATOTOMY.

This patient was also shown by Dr. Chetwood. The man was sixty-three years of age, a peddler by occupation. His principal complaint had been that he was compelled to urinate at least every half hour, day and night, which was accompanied and followed by considerable pain. The speaker said that urinary symptoms of this character occurring in a man of that age would naturally suggest prostatic hypertrophy, causing vesical insufficiency and cystitis. The examination of this patient bore out this hypothesis. While the prostate proved to be only moderately enlarged, the bladder contained seven ounces of residual urine, and the Thompson searcher, introduced into the bladder, recognized an obstruction at the urethral orifice in the nature of a bar. Operation was performed on February 27, 1903. Perineal section, followed by digital examination of the bladder, showed a tight vesical orifice, an elevated and hypertrophied median fold and a deep *bas fond*. This bar was incised with the galvano-cautery instrument in two places, each being three-fourths centimeter in length, forty-five seconds being allowed for each cut. A perineal tube was then introduced and left in place for five days, at which time it was removed, and in a few days the patient began to urinate through the natural channel. He was pronounced cured in three weeks. Summing up this method of operating, the speaker said that it is essentially one of drainage,

the aim being to effect, as nearly as possible, the reëstablishment of the normal condition of bladder drainage, with the minimum amount of risk, the greatest dispatch, and without removing more of the prostate gland than is necessary in order to accomplish this purpose.

TWO CASES OF SKIN DISEASE.

Dr. Victor C. Pedersen presented two interesting cases of skin disease, one of scaling papulo-squamous syphilide, some of the lesions of which resembled psoriasis, and the other of generalized nummular psoriasis, strongly suggesting syphilis at first sight. The histories of the patients were as follows:

Case 1. Male, twenty-two years old. Eight months ago had a chancre, which left behind the typical indurated scar on the prepuce. Nearly three months afterwards a rash appeared on the skin, and the man consulted a physician, who prescribed antisyphilitic remedies, which were taken in an irregular manner for a short time, resulting in a more or less complete disappearance of the rash. About three weeks prior to his appearance at the New York Hospital, about the middle of October, the outbreak returned with greater virulence and wider dissemination. When first seen at the New York Hospital, he presented a generalized papulo-squamous scaling rash all over the body. Some of the lesions, especially near the elbows and shoulders, were so large and the scales so numerous as to strongly suggest psoriasis. Differential diagnosis was made by the presence of typical mucous patches in the mouth and typical lesions of syphilis on the palms of both hands and soles of both feet. Tonics, mercurial inunctions, and ascending doses of iodide of potash in about three weeks caused practically all of the small lesions to disappear, and only the large ones remained. The character of these larger lesions was still somewhat suggestive of psoriasis, and the case was presented for its interest and for differentiation by the members of the society between these two diseases.

Case 2. Male, twenty-four years old. About five weeks before he applied for admission to the New York Hospital Out Patient Department a generalized scaling rash appeared all over his body. In this case the lesions were frankly those of psoriasis, but resembled those of syphilis somewhat in being comparatively small and in being scattered everywhere over the body, excepting on the soles and palms. The diagnosis was made through the absence of sole

and palm lesions and of lesions in the mouth, and likewise by the distinctly psoriatic condition of the backs of the hands. Three weeks of treatment had caused the scaling to practically disappear, and the color of the underlying skin had assumed a much more healthy appearance. The treatment had been simple, consisting in simple diet and regular physical exercise and ascending doses of Fowler's solution of arsenic, with chrysarobin ointment, about ten per cent applied to small areas of the body in turn, from night to night, and ten per cent boric acid ointment applied to other parts of the skin to keep the scales as soft as possible.

Dr. F. H. Dillingham opened the discussion of Dr. Pedersen's cases. With regard to Case 1, he said he thought most of the lesions were syphilitic. On the patient's back were a large number of lesions undoubtedly syphilitic, and those on the front portion of the body resembled these, but in syphilis there is atrophy or loss of tissue. Sometimes the lesion is too small to be recognized with the naked eye; but if there is loss of tissue, it cannot be psoriasis. It leaves the skin perfectly normal, except often pigmentation disappears. The speaker made a diagnosis of syphilis and psoripheral eczema of the scalp.

Dr. E. L. Keyes, Jr., said that the case reminded him of a patient about twenty years of age who came to him with psoriasis all over his body. The case was supposed to be psoriasis, as the lesions were characteristic; and although the question of sypphilis was brought up, there was no history and no evidence of a primary lesion. More psoriatic lesions appeared, characteristic ones on the palms of the hands and soles of the feet. This seemed to point to syphilis, and the patient was put on mercury, and the lesions promptly disappeared.

Dr. Pedersen said that he had brought the patient before the society for diagnosis because, three weeks before, when he first saw the man, he was put on syphilitic treatment and the improvement was marvelous. The morning of the meeting, however, the speaker and his colleague at the New York Hospital had failed to agree on the diagnosis, the speaker considering it syphilitic and his colleague claiming the patient presented a combined lesion.

SUBPHRENIC ABSCESS.

Dr. J. A. Bodine presented this patient, a man thirty-five years old, who had come to him with a previous history of pneumonia

six weeks before. The pneumonia had kept him in bed for thirteen days, and he had been up and about for eight days when pain and fever returned. He was referred to the speaker with a diagnosis of encysted empyema. Sweating, emaciation, and septic facies were present, and on the right lower side of the chest there was well-marked bulging. Respiratory signs were absent in this locality. To verify the diagnosis, a hypodermic syringe was inserted in the upper part of the bulging mass, between the seventh and eighth ribs, and pus was withdrawn. A section of one and one-half inches was made in the ninth rib, care being taken not to go through the diaphragm. There was no pus, but the liver and diaphragm could be felt intervening. The needle was inserted again between the seventh and eighth ribs, and pus was withdrawn. A second incision was made at this point, and when the pleura was reached six or eight ounces of clear serous fluid was found. When the finger was inserted into the second opening a dome-shaped mass was found rising over the liver. The lower border of the lung was defined and a fluctuant subdiaphragmatic abscess diagnosticated. The diaphragm, was incised with a knife, and eight or ten ounces of pus withdrawn. A drainage tube was carried through the lower wound. The fever has entirely disappeared, and the patient is on the road to recovery.

Dr. Morris Manges said that to make a positive diagnosis in these cases is impossible. Absence of pneumococci might have given the clew to the origin of the subphrenic abscess. There is no part of the body in which one is more liable to err than in the lower portion of the pleural cavity in the recognition of fluid. There is nothing which fluid cannot simulate. It was Leyden who pointed this out in 1887, and gave to it the name of pyothorax subphrenicus. Since then a number of cases have been reported as secondary to pneumonia, but in such cases pneumococci are usually found in the pus from the subphrenic abscess. Another condition which makes differential diagnosis difficult is abscess of the liver, as differentiating this same condition from secondary effusion into the pleural cavity. In almost every case one finds the localized point of tenderness over the liver, and this indicates where the aspirating needle should enter. In abscess of the liver the dullness and flatness is higher in the axillary line than it is anteriorly, and respiratory conditions are present which are absent in empyema.

UNUNITED COMPOUND FRACTURE OF THE TIBIA.

Dr. L. L. Roos presented a patient who, four weeks before, had fallen in the street. Examination revealed a compound fracture of the tibia, with two simple fractures of the fibula. The patient was sixty-seven years old, and had suffered from locomotor ataxia for eighteen years. For twelve years he was treated with silver nitrate. Four weeks after the accident there was no sign of healing in the fractures. The external wounds had become gangrenous. During his hospital experience the speaker had seen three cases of locomotor ataxia with fractures of the leg, and all three patients had been kept in bed for four, five, and six months without any union resulting, and finally amputation had to be resorted to. From lying in bed for four weeks the patient was developing paresis of the bowel, and movements were induced with great difficulty. Catheterization was necessary to draw urine at all. There was not even fibrous union in the fractures.

Dr. W. B. Pritchard said that there was no arbitrary rule for union in such cases. Sometimes it is impossible to obtain union, and in other cases the results are unexpectedly good. This kind of fracture is not peculiar to locomotor ataxia, but often occurs in connection with peripheral neuritis and with multiple neuritis, and takes on exactly the same characteristics. The bones are friable, partake of the general trophic disturbance, easily fracture, and show resistance to union. These fractures do well unless complicated. If simple, there is no external disturbance of the circulation.

The paper of the evening was read by Dr. F. H. Dillingham, was entitled

ALOPECIA AREATA,

and was in part as follows:

"Alopecia Areata should only be used to designate a disease where the hair falls out in one or more patches, which increase in size by spreading at the periphery and leave a bald area without any apparent inflammation of the skin. In a majority of cases the disease is confined to the scalp, and after the hair stops falling out, the patch may remain stationary or new hairs, which are usually at first fine lanugo hairs, appear at the margin or in the patch. While the disease is progressing the hair at the margin is loose, with atrophied roots, and can be easily pulled out. The skin shows no signs

of inflammation, is smooth, shiny, and slightly depressed. There has been a great difference of opinion as to the etiology, some claiming it to be a trophoneurosis and others paretic. There is no question but that there are a number of cases of alopecia occurring as the result of shock or injury to a nerve, but they do not have the definite clinical history that we have in alopecia areata and should not be called such, but designated as alopecia neurotria. Simply because an area is devoid of hair, it should not be called alopecia areata.

"The manner of spreading at the periphery, the inflammatory process in the corium, the fact that the loss of hair does not follow a nerve distribution, and the number of epidemics reported seem to be conclusive evidence that the disease is parasitic and slightly contagious under favorable conditions. Although a number of different organisms have been found, none of these have been proven to be the cause of the disease.

"Salourand claims it is the same bacillus found in seborrhea, but it is also present in comedones of acne. He also claims that it occurs only after puberty, which does not explain the many cases in children. Crocker and Hutchinson believe it to be related to ringworm, but there is no proof.

"The disease which will give the most trouble in diagnosis is ringworm of the scalp, in which the patch is inflamed, the baldness is not complete, and there are the characteristics, short, broken-off hairs, with short ends. In doubtful cases the microscope will decide.

"In favus, the yellowish crusts, incomplete baldness, inflammatory symptoms, and atrophy will enable one to make a diagnosis. The prognosis is almost always good if the disease has not lasted long enough to destroy the hair follicles. If acne has been properly treated for two months, and there are no lanugo hairs, the chances are the hair follicles have been destroyed and there will be permanent alopecia. If there is any defective condition of the general health, it should be corrected; but aside from this, internal treatment is useless. Besides a large number of drugs, Rontgen rays, Finsen light, and radium have been used.

"Chrysarobin will give the best results in most of the cases, but it should not be used on the face or over too large a surface at one time. It is best used with vaseline, gr. xv. to the ounce, and it is

SURGICAL INFIRMARY

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High school and first grade teachers' certificates constitute the minimum requirements for entrance. College graduates are permitted to take the first and second years' work in one session. The entire course covers four years, and is strictly graded. The work of each year must be completed before any student can be advanced to the studies of the next succeeding year. Certificates of proficiency from other reputable medical colleges will be accepted, and students from such colleges will be advanced accordingly. Our college and hospital clinical facilities have never been so good, for **under a new city law the clinical staff will have control of all charity patients.** We welcome post graduates and encourage post graduate work. The next session begins Thursday, October 1, 1903. Prospective students should write to the Secretary

DR. G. C. SAVAGE,
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well not to use too strong a preparation at first. We aim to produce a mild dermititis in order to obtain the benefit of the emigration of the white blood corpuscles and destruction of the organisms. The preparation should be thoroughly rubbed in with considerable friction every night for a week, and then discontinued to see if the disease is still progressing. After the alopecia has stopped spreading, stimulating applications with massage should be used to bring an increased blood supply to the part and aid in the nutrition of the new hair."

Abstracts.

COLLARGOLUM BY INTRAVENOUS INJECTION IN ERYSIPELAS.*

BY WARREN COLEMAN, M.D.,
Professor of Clinical Medicine, Cornell University, New York.

The favorable reports on the intravenous use of collargolum in various infections induced Dr. Coleman to try the drug. The results were sufficiently encouraging, especially in erysipelas, to warrant publication.

He used doses of five to ten centimeters of a one per cent aqueous solution. All who have used collargolum agree that it is harmless. As to technique, any sterilizable ten centimeter syringe is suitable. The veins at the elbow bend are the most convenient. The site should be sterilized and covered with gauze until the needle is inserted. A bandage tied about the arm brings out the veins. If they do not appear readily, the arm should hang over the edge of the bed for a few minutes. In no case was it necessary to cut down to the vein. A hypodermic size needle is the best, its eye being uppermost. The syringe should be held as nearly as possible in the long axis of the vein. If the vein shows tendency to roll from under the needle, slight axis traction will steady it. The disappearance of resistance before the needle generally shows that it has entered the vein. It can often be felt to "pop" into the vessel. If doubt exists, a small quantity of blood may be sucked up. All air should be removed from syringe and needle beforehand. The syringe should be inclined, so that any contained air

*Abstracted from the Medical Record, Nov. 21, 1903.

will rise to the piston. The fluid must be injected slowly. The vein should be covered with gauze and bandaged rather tightly immediately after the needle is withdrawn. Collargolum should not be allowed to escape into the tissue. When this precaution is taken, patients rarely complain. Very little or no reaction at the site occurs, and the same vein may be used within a day or two.

The author then details five cases of erysipelas. Three of them promptly recovered after single injections, one of them after two injections, and the last after three injections. Being convinced by an experience of some twenty cases of various diseases of its harmlessness, he recommends that the method be tried in appropriate cases. So impressed is he with the possibilities which the intravenous use of collargolum holds that he is actively continuing the work upon cases placed at his disposal by Prof. Loomis.

ORAL SEPSIS AS A CAUSE FOR PERNICIOUS ANÆMIA.

In an article on this subject by William Hunter, M.D., Edin. F. R. C. P., London, published in the *Lancet* (January 27, 1900), the author gives the following conclusions:

"1. Pernicious anæmia is a special form of chronic blood-poisoning—a toxæmia.

"2. It is the result of a special infection of the digestive tract, especially of the mouth and stomach, and probably, although to a less degree, of the intestines.

"3. The chief source of infection is through the mouth from long-continued and neglected cario-necrotic conditions of the teeth, and so sometimes, possibly, from stomatitis arising from other causes.

"4. The usual effect of this infection is a chronic infective catarrh of the mouth and stomach, which may in time lead to deep-seated changes—*e. g.*, ulcers of the mouth and tongue, chronic glossitis and atrophic changes in the tongue, or chronic gastritis, with atrophy of the gastric glands.

"5. The evidence of the infectivity of the organisms of dental decay are overwhelming.

"6. The infection is chiefly streptococcal, and probably derives its special characters from being of a "mixed" character.

"7. Such infection the more readily occurs if the stomach or intestine is already, from any cause, the seat of disease.

The above conclusions suggest certain new considerations in regard to treatment, of which the chief one is the importance of minute attention to the hygiene of the mouth and especially of the teeth, with the immediate removal of every source of infection."

The importance of oral cleanliness, which is emphasized by Dr. Hunter in the above article, has lately received much attention from the medical profession. Various forms of infection, both local and general, have been traced to the mouth and teeth. In Glyco-Thymoline we have an excellent antiseptic mouth wash which not only cleanses but, on account of its alkaline reaction, prevents further decay.

It is a well-known fact that the formation of lactic acid causes decay of the teeth, and that this process is absent or at least proceeds very slowly when the saliva is alkaline. Normal human saliva is slightly alkaline, but the alkalinity is so weak that few mouths are capable of a prompt recovery from the acid condition, nor is the alkalinity usually strong enough to counteract the acids of decay; hence it seems rational to endeavor to supply this deficiency.

Saliva is composed in part of mucus, which is readily soluble in a properly combined alkaline solution, while it is insoluble in alcohol, ether, or acid solutions. Bacteria develop rapidly in this undissolved and undisturbed mucus in and about the teeth, causing continued and increased acidity of the saliva.

These facts indicate that an alkaline solution is needed at the portal of the body for protection.

Dr. A. H. Peck's analysis of a number of mouth preparations proved that but one of the many had the essential feature for the purpose desired—namely, that of alkalinity. This solution was Glyco-Thymoline.

Alkaline saliva seems an undoubted aid to digestion; and if it can be induced to flow and be kept alkaline, many stomach disorders will disappear.

The mucuous membrane, under the action of Glyco-Thymoline, becomes hardened and normal, and naturally offers greater resistance to disease. The daily application of the remedy as a mouth wash does much good, maintaining an alkaline or normal condition.

Glyco-Thymoline is a scientifically prepared solution, of the alkalinity of blood serum, and of correct specific gravity, forming an agreeable, nontoxic, alkaline alterative. It readily dissolves the mucus which forms part of the salivary secretion, and thus penetrates every cavity of the teeth and mouth. It has a distinctly alterative effect upon mucous membrane, acting by exosmosis, thus not only reducing inflammatory engorgements and establishing a normal condition, but also maintaining this condition by continued use.

UROTROPIN IN THE PROPHYLAXIS OF SCARLATINAL NEPHRITIS.*

BY DR. J. WIDOWITZ, GRAZ, AUSTRIA.

The beneficial action of Urotropin in vesical catarrh, pyelitis, and phosphaturia recorded by so many authors and ascribed to the disinfectant action of the formalin separated from it in the urinary passages, induced me to use Urotropin in scarlatina to prevent the advent of nephritis. For it is probably correctly assumed that the latter is due to the as yet undetermined scarlatinal microbe or its toxines, and an efficient antibacterial agent applied to the site of the infection may inhibit the pathological changes that mark the renal affection.

During the past three years I used it in one hundred and two cases. From three-quarters to seven and a half grains were given thrice daily for three consecutive days at the onset of the disease, and the same doses were given at the beginning of the third week, when nephritis most commonly occurs. Children from one to fifteen and an adult of twenty-one were treated in this way. The remedy was always well borne. I have not seen nephritis occur in a single case, although it is the most common complication of scarlatina. Johannessen has seen it in as few as sixteen per cent and as many as ninety per cent of the patients. It occurs especially in mild cases, which were the most frequent.

Two cases deserve especial mention. A girl of eleven sickened with a fairly mild attack. On the fifteenth day large quantities of albumin were present in the urine. Five grains Urotropin t. i. d.

*Abstracted from the Wiener Klinische Wochenschrift, Oct. 1, 1903.

Two days later the albumin permanently disappeared. Another girl of eleven had had paroxysmal hemoglobinuria for eight years. When she fell sick with scarlatina, hemoglobinuria at once appeared. Urotropin five grains t. i. d. Urine free from blood coloring matter on the third day. On the fourteenth day, temperature rose to 100.6 degrees and hemoglobinuria reappeared. On the eighteenth day Urotropin was again given, blood coloring matter disappearing four days later. The absence of nephritis in my one hundred and two cases may possibly have been accidental, but it certainly urges to further clinical trials.

Records, Recollections and Reminiscences.

THE WINDER HOSPITAL, OF RICHMOND, VA.*

BY ALEX. G. LANE, M.D.,
Late Surgeon C. S. A., of White Oaks, New Mexico.

Standing in the hall of my *Alma Mater,* where in the prime and innocence of my youth, forty-five years ago, I was commissioned to care for the lives of fellow-beings, I would not, in the happiness of this moment, rend from my life's history any of its darkened leaves; for in the bright eyes and intellectual faces around me I see written upon memory's tablet, in golden characters, your confidence and esteem. No! Welcome the past, since it is the background of patriotic adherence to principles enunciated to us by Jefferson, Washington, Henry, Campbell, Shelby, Morgan, Rutledge, and a host of others, who combined eminently all the nobler qualities of heroes and statesmen and left to the world names synonymous with virtue and luminous with public integrity. No! Welcome the present, since the love-crown of consciousness of duty done has drawn us together, pointing each other to altars of courage and constancy to our own Southland homes of beautiful women, sunshine, and flowers, with only one glory, to prove ourselves faithful to friends and formidable to foes. Whatever humble or

*Read at meeting of Associaton of Medical Officers of the Army and Navy of the Confederacy. at New Orleans, La.

important part either of us may have performed in this greatest drama, "Liberty Enlightening the World," we meet to-day wiser men, knowing the achievements of that "mighty conflict of brothers" which has accomplished the solidity of States, the perpetuation of the Union, and its present distinguished position before the world—arbiter of nations and empires. We meet to-day as at camp fires of yore to recite to each other our little part fought, won, or lost.

Having received degrees of Bachelor and Master of Arts at Centenary College, Jackson, La., in 1854 and 1856, twelve months resident student of Charity Hospital, graduate of Tulane University, class of 1858, a successful cotton planter in Carroll Parish, La., I submitted the question of slavery to the arbitrament of the sword, believing that it was in the defense of its plain relations to the constitution of the United States, entered service in my native State, with the Mississippi College Rifles, elected to deliver the valedictory to citizens of Clinton, Miss., in the vigor of youth, burning with inspiration of patriotism, I fired a thousand assembled citizens to shouts as I walked off the platform, carpeted with showers of bouquets from hands of Mississippi's fairest daughters. I allude to this occasion not in any self-praise but to recall to your memory how the fires of secession were then burning, and how the hearts of our boys were inspired by fathers, mothers, and daughters of the Confederacy to perform well their part. After six weeks in camp of instruction at Corinth, Miss., we were ordered to Virginia with Col. Burt's Eighteenth Mississippi Regiment, fought the first battle of Manassas; received commission as surgeon P. A. C. S. dated June 6, 1861, as I came off the battlefield of Ball's Bluff, and made staff surgeon by commanding Gen. Evans.

The Federal sick and wounded received from the battle of Ball's Bluff (one of the most decisive and fruitful battles of the war, with only thirteen hundred Confederate muskets engaged, but which eventuated in the killing of two thousand one hundred men, capture of eight hundred stands of arms and three mountain howitzers, sending seven hundred and fifty prisoners to Richmond, and turning back a column ten thousand strong commanded by Gen. Stone, who was afterwards cashiered, and where Gen. Baker, of Oregon, was killed) who were not able to be forwarded to prison quarters at

Richmond were placed in a hospital organized by me and in my charge at Leesburg, Va., and received the same bedding, rations, and medical attentions as Confederate soldiers.

A very interesting case (a man of the Seventeenth Massachusetts Regiment, a native of the mountains of Vermont, a perfect athlete, over six feet high, one hundred and eighty pounds in weight, and never sick a day in his life) was admitted with his arm torn to fragments by grapeshot. I amputated the arm just above the seat of injury, in the upper third of the humerus (using this scalpel for a surgeon's knife and a carpenter's tennon saw to cut the bone), and it healed by first intention and he was discharged in fourteen days after receipt of the wound, sound and well. The ligature was removed on the ninth day with but a drop of suppuration at each suture, and in three days the cicatrix was complete.

The Winder Hospital and grounds—covering one hundred and twenty-five acres of land, with a capacity of four thousand eight hundred patients—was organized in April, 1862, and conducted by me for three years, or until within ten days of Gen. Lee's surrender. It consisted of six divisions, each in charge of a division surgeon and six assistants, with its appropriate dispensary, laundry, kitchens, and corps of matrons, nurses, and attendants; the whole surrounded by a guard of one hundred and twenty-five men under a commissioned captain. Attached to the hospital was the most approved Russian, steam, plunge, and shower baths, a bakery with a capacity to bake for ten thousand men daily, sixteen acres of hospital garden (worked by convalescents), a dairy with sixty-nine milch cows, with appropriate barns and stables, the dairy yielding three hundred gallons of milk daily, an ice house forty feet square and twenty feet deep filled with ice, a commissioned captain of commissary with commissariat, and a medical examining board of three surgeons, giving me a command, at twenty-seven years of age, with eight hundred hospital attendants, ranging from two to five thousand men.

I had a six-foot ditch cut down a hollow from the central grounds of the hospital leading toward the James River, over which was constructed a line of water closets and two ten-thousand-gallon water tanks, which were pumped full of water and the ditch flooded every other day, carrying off all debris and filth from the hospital grounds. By permission from the Secretary of War, I had con-

structed two canal boats that run up the Kanawha canal and furnished the hospital from the mountains with weekly supplies of fresh butter, eggs, chickens, geese, turkeys, honey, and every other necessity that the vast hospital fund amounting to twelve hundred and twenty thousand dollars, created by commutation of army rations and from the hospital bakery, could obtain for the sick and wounded, who were often regaled in their hot fevers during the summer months with ice cream, custards, and lemonades. On sundry occasions the Federal sick and wounded were sent to this hospital, where they received the same rations, medical attentions, and privileges as other patients. Frequently for weeks the bread for prisoners on Belle Island and Libby Prison was baked at the hospital bakery, and was the same in kind as that used in the hospital. All wines and liquors—the best grades of which were obtained through the personal friendship of Mrs. Snowden (blessed be her memory!), President of the Ladies' Hospital Association, of Charleston, S. C., via blockade runners from Nassau—were dispensed through hospital matrons. No medical officer was allowed to touch it under penalty of immediate orders to the field.

The government of Winder Hospital was the inspiration of every official and attendant, with a laudable ambition to excel. To this end I told every medical officer reporting to me for duty, that printed rules and regulations of the hospital were posted in every apartment; that I was its head, fired with love and zeal for duty; and that every official and attendant in it was there with a high purpose and a firm resolve to make for it a record—one harmonious whole in loving-kindness to its sick and suffering.

"Will you be one, with its chief surgeon, to add joy to your environments and say when you lie down at night, 'I have lived this day to relieve the suffering of those around me?' We are all here, in this mighty conflict thundering at the very doors of our capital, for a record of every duty accomplished. I well know that it is a custom with many medical officers in the field, when they draw their monthly supplies of liquor, to call in their regimental officers and drink it up. I well know that many officials when they get into new suits of clothes, a star or bar on their collars, begin to feel that they are better and look down on the rugged soldiers around them, but this is not truth. Many patients in this hospital are socially, intellectually, and financially our peers. You will be required to

treat them and every attendant with the same courtesy and decorum that marks you to be a Southern gentleman. Believing that we always get the best there is out of our fellow-beings—that is, of their mind and heart, I make this appeal to you to emulate the example of your chief surgeon in the fulfillment of every personal and official duty; and now I challenge you—every person in this hospital—to see that I toe the mark of its regulations, and rest assured that I shall see that every official performs well his part." At trumpet call every day, except Sunday, the six division surgeons met me at my office to inspect one of their divisions. This I did promiscuously, so that they were all compelled to keep their divisions in perfect order, not knowing their day for inspection. If I found everything in commendable condition after inspection, my rule was to dismiss them with some complimentary remark to the surgeon in charge. From this sprang a laudable ambition in each division surgeon's heart to have as much said for them upon their day of inspection. This rule worked so successfully that after a few months I confessed to them that it was my secret of government of Winder Hospital, and I then reminded them that the lives of all the great rulers and governors in the world teach us that man, to make a success in all he attempts, must *first* become interested in the work, *second,* learn to *control himself* before he is fitted to control others, and *third,* give it inspiration *by personal example.* I then exhorted them, in glowing language flowing from my own heart, not only to adopt this rule in their respective divisions, but each to labor to excel the other in indicting it in the daily life and labor of every subordinate official and attendant in their divisions of the hospital. They responded promptly and pledged the best there was in them to my support. This *proved* the *key* to *success.*

I next organized a quiz class, consisting of six division surgeons and myself a faculty, each in charge of a chair in surgery, chemistry, therapeutics, anatomy, etc. We met weekly, having lessons assigned for the previous week's study, when the professor for each evening would question the class; then at the close of the lesson, close his book, and have us come back at him, every member with a question on the lesson. The result of this work was that we were all refreshed in both theory and daily practice, drawn to-

gether both socially and intellectually. Every member passed with flying colors before the Army Medical Examining Board, and thirty-three assistant surgeons in Winder Hospital were promoted to full surgeons.

It may interest you to know that Miss Emily Mason, niece of Senator Mason, of Mason and Slidell Ambassador notoriety, was chief matron of the first division of Winder Hospital, and that her personal friends, two daughters of Robert E. Lee, Mrs. Secretary Randolph, Mrs. Grant, wife of the richest tobacconist in Richmond, with many others, would frequently drive out from Richmond in their fine carriages to visit the sick and wounded, became interested in the family history of some wounded soldiers, sat down by their bedsides, and wrote letters to their loved ones at home, and even fed them like mothers with delicacies and viands they would bring out daily from their own tables.

I hold before you chief surgeons the official record of Winder Hospital Fund Book, which I now commit to the archives of army and navy surgeons, in which will be found the cardinal facts that I disbursed twelve hundred and twenty thousand dollars of public funds from April 1, 1862, to March 1, 1865, that seventy-six thousand, two hundred and thirteen sick and wounded were admitted, eleven thousand, five hundred and thirty were transferred to other hospitals, leaving sixty-four thousand, six hundred and eighty-three to be treated in Winder, with three thousand, two hundred and fifty-nine deaths, just five and two-tenths per cent of mortality —a record at that day unprecedented in the annals of general military hospitals, whether in the North or Europe.

I hold before you this clipping from the Richmond *Enquirer* of the proceedings of the Confederate States Senate, in which you will find that as early as September 25, 1862, the mortality in General Hospital No. 2 was ten per cent; in No. 13, fourteen per cent; in No. 9, twelve per cent; in No. 5, thirteen per cent; in No. 23, twelve per cent; and in the balance each eight, nine, and ten per cent, except Winder, a remarkable exception, where, out of twenty-two thousand, eight hundred and seventy-four patients treated, the mortality was only six per cent.

In conclusion, permit me to remind you, comrades, that every person, State, or nation that stands for the defense of the right and the truth must have a history of conflicts and sorrows; that the

memorial which binds you to the great heroism and mighty sacrifices of the past has already become a bow of promise to American grandeur and power through the gallantry of your sons during the Spanish-American war, forming a mighty prism to reflect the noontide radiance of your achievement into a halo of glory to encircle the brow of your departing worth; that to-day this giant young republic is thundering past the old nations and decaying monarchies of the East with the rush of the limited express; that her public school system is not only the boast and pride of her citizens, but the palladium to her progress and power; and that, having produced seventy billions of wealth in a little over one hundred years, she is to-day, in population, annual saving, public credit, agriculture, mining, manufactures, consolidation of personal capital (as factors to commercialism), education, and munificent endowment of universities, a blazing meteor before the civilized world, forty per cent richer in material wealth than any nation on the earth; and that the Anglo-Saxon race now belts the world. It has laid the foundation of our Western republic and started it off on a career of monumental commercialism, progress, and prosperity. Under its beneficence to the human race, universal education, and a free ballot, its grip upon the masses will not be relaxed as the battle for unity, right, and justice to its humblest and poorest citizen waxes hotter, but will rather tighten its hold and increase its power (see late merger decision) over trusts and commercialism, until language, custom, and purpose are one, until, under the banner of control of the holy trinity of liberty, religion, and universal higher education, America will give law to the world and Anglo-Saxon supremacy will mold its multiform elements into complete accord with this union, and the Christian religion shall direct the whole for humanity and God.

Are you not all proud, gentlemen, to know that you are living factors in this grandest achievement of the nineteenth century for the elevation, advancement, and happiness of man?

Editorial.

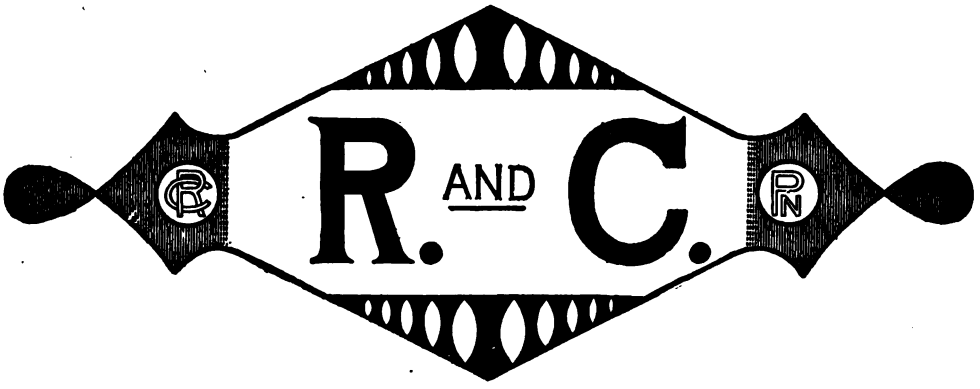
BEGINNING ANOTHER VOLUME.

Quite a number of our subscribers (some who have been with us continuously for years, others for a shorter time) have gratified us no little, not only with their renewals of subscription in advance, but more by the kindly and complimentary expressions in regard to our editorial work. It demands not only the personal acknowledgments made, but also a continued effort on our part to see that the new year shall bring them no disappointment so far as concerns the reading matter to be found in THE SOUTHERN PRACTITIONER during the coming months. The encouragement will justify our most earnest and sincere efforts along all lines of medical and surgical progress. A single letter from a recent graduate in medicine, his subscription beginning just one year ago, suggests that the matter contained in our "Records, Recollections, and Reminiscenses" might be filled with other matter. To this we will say that when this department was added to the journal sixteen pages more reading matter were added to its former number of pages. So this is, as it were, "a chromo" thrown in, which can be read or left unread. It has, and will contain, matter covering a period in which the literature of our medical friends in the South is quite limited. It has received commendation after commendation from surgeons who wore the "blue" as well as those who wore the "gray." It has placed on the printed page valuable facts and incidents that would perhaps never have seen the light, that every doctor, especially in the South, may well feel a pride in. The work that was done in field and hospital by the Confederate States medical staff was too valuable to be left unrecorded. Much of it can never be rescued from oblivion, but our efforts in rescuing so much of it as we possibly can, we feel confident, will be appreciated not only now but in the years to come. Yes, we propose to continue this as well as put forth our best efforts along all lines of progress and advance.

The following letter from Dr. James M. Holloway, of Louisville, Ky., we beg leave to place before our readers:

"Your December issue notes the death of three of my Confederate friends —Chisholm, Gaston, and Mitchell. Gaston and I were together on the field, and Bob Mitchell and I were everywhere together and like brothers.

"I am only a year or two younger than the youngest of the three, and, while still in active practice and teaching, am looking forward to some incident of exposure that will put me to bed, and thus finish me. It rejoices me to see such favorable notices of these three good men in your journal—men who were so modest that they would shrink from any ante-



TIRED of using the many so-called digestive preparations on the market, which give you only positive results in about one case in ten, then try * * * * * * *

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mortem eulogy that was strickly personal. I thank you kindly for the information this number of the journal contains, and am pleased to discover other material that will be valuable to your list of subscribers."

MEDICAL SOCIETIES.

In the numbers of this journal of last year medical organization has occupied quite a prominent place. The time was opportune for active work, and if we have added a little even to the great work that has recently been accomplished from one end of the land to the other, we can feel that our efforts have not been in vain. Having always had an abiding confidence in the great good that would result to all—both the profession and its clientele—in a thorough organization, we have endeavored to do our part in its behalf. However, we do not propose to stop yet, and sincerely hope that the coming spring months will add as many to the membership of the county medical societies throughout the entire country, and especially in our own State, as was done in the past year.

Take a careful look at the membership of the American Medical Association during its entire existence for many years of any State or local organization, and you will find enrolled therein the ablest, the most successful, the most prominent medical men of the particular time under consideration. Our busiest members have found time to participate in the meetings, if not every year, at least a great proportion of the time. Occasionally we have made overtures to professional men in regard to participating in society work, and have been met with the statement, "We are too busy," "Could not spare the time;" yet a careful observation has forced the conclusion that such would have done better if they had never opened a medical book, and had devoted their time and talents to some other vocation. Unquestionably times do occur that professional or other duties will prevent attendance on a given meeting of a local or State society, and all cannot attend the annual meetings of the National Association; yet, if each member of the profession will but endeavor to participate in as many meetings of his local society, and occasionally attend a meeting of his State organization, he will find that the time so spent will be of more intrinsic value in the end than double the time spent in any other duty—yes, we regard this as a duty incumbent on any practitioner acting for the best interests of himself and those dependent on him for professional services. This may be regarded as a strong statement, yet it is the result of careful observation during more than forty years of professional life, and we know will be substantiated by the leading medical men of this and all other enlightened and civilized countries.

Much has been said about the benefits and advantages of organization. Its results are seen everywhere, and to no body of men is it so important, so necessary and essential, as it is to the members of the medical profession. Except in occasional instances of consultation, their very work

leads them to segregation and isolation. A daily duty of making visits as a duty renders to some extent social visiting irksome; and even though one is an omnivorous reader of standard and periodical literature, he is apt to get into a groove, be limited in his views and resources, narrow in his observation—all of which is overcome by an occasional meeting with a collective number of others, some his inferiors, others his peers, and possibly a few his superiors in like work. By such association he adds his experience to that of others, and has the far wider experience of others added to his. Not all at one time, but a little at this meeting, more at another, and when he has established the habit—we are all more or less creatures of habit, of becoming a regular attendant at even local society meetings—it is astonishing how his entire methods, measures, manners, and life in all its technical details are broadened, advanced, and materially increased.

By organization and regular meetings personal jealousies, petty bickerings, slanderous and scurrilous backbitings disappear and are supplanted by a broad and liberal ambition and emulation as to who can excel and who can add the more to the sum of professional knowledge, skill, and correct technique. Nor is it alone from the papers, essays, and discourses thereon that we can and do derive a national benefit. Some of the most practical and valuable ideas and suggestions ever received have been obtained in the personal conversation with other medical men in attendance on a meeting. While many valuable ideas and thoughts have resulted from careful attention to the regular programme, yet some of far more value have been obtained in the social intercourse and conversation on assembling before the meeting was called to order and after its close.

However, as we have been, to some extent, running a "serial" along this line for some months past, we will bring this the first section of 1904 to a close with the following extract from a communication by Dr. George J. Monroe, of Louisville, Ky., in the *Cincinnati Lancet and Clinic* of December 12, 1903, which is quite "meaty," and contains some very pertinent suggestions. In giving his views of the last meeting of the Ohio Valley Medical Association to our valued contemporary, he has the following:

"I was invited by Dr. A. M. Hayden, Chairman of the Committee of Arrangements, to attend the annual session of the Ohio Valley Medical Association, which met at Evansville, Ind., November 12 and 13, 1903. He requested me to prepare a paper on some medical subject and to read it at this meeting.

"I accepted the invitation and prepared a paper for the occasion. I noticed that a number of doctors received the same invitation and agreed to prepare and read papers at the meeting. Such names and papers appeared upon the programme, and yet many of those who made this promise did not put in an appearance at all. There were six or seven Louisville doctors who had promised to be present and to read papers who did not attend, and yet I saw in the daily papers that some of them had been present, had

read papers, and these papers had been ably discussed. Now, I believe that a physician should fulfill a promise of this nature. The programme is arranged for certain papers and discussions; and if these papers are not read, it is a disappointment to those in attendance, for they go with the expectation of hearing these papers read and discussed. It is also a disappointment to the committee of arrangements, who have been depending upon these promised papers. Furthermore, I think we may say, very often it is simply lying on the part of these physicians. Of course circumstances may arise which would make it impossible for some physicians to attend, but we would hardly suppose that these conditions would take place at one and the same time with a dozen. I think there were nearly that number absent who had agreed to be present and read papers.

"Fortunately, there were a number of volunteer papers and discussions which profitably filled up the time. Physicians promising papers and having their names appear on the programmes, and then not complying with their promise, looks to me to be a cheap way of advertising; hardly an honest way, I think. Having promised to read a paper at this convention, I considered myself in duty bound to do so.

"I will here say a word about papers and the preparation of papers for medical associations. I took for the subject of my paper 'The Rectal Specialist, or the Birth and Evolution of the Rectal Specialist'—a very broad field to condense into a twenty-minute paper. I am not gifted with a large vocabulary of words, yet upon reading the first paper I prepared upon the subject I found that it took me fifty-four minutes to read it. I had not then said all I wanted to. I knew this would never do, so I began to eliminate and condense. I rewrote the paper, cutting out all it seemed to me that I could. I found that it took thirty-two minutes to read this paper. Again I rewrote the paper, and upon reading it this time I found that it only required nineteen minutes. I compared this paper with the first and second, and I was surprised to find that I had really said more than I had in either of them. When I say I had said more, I mean more facts and matter actually pertaining to the subject. Now, then, I think this will apply to the majority of papers read before medical associations. The greater number of them could be materially condensed and yet contain all that is expressed in the long papers. How many papers we find that are filled with useless matter, matter that has no relation to the subject which the paper is supposed to treat—matter, in fact, that the general practitioner cares nothing about—matter that instructs no one! How many writers shoot all around the bull's-eye and hardly ever strike the pupil! What cares the busy doctor about a lot of statistics and data relating to the prostate, pancreas, spleen, thyroid gland, etc.? No, what we want is to learn the best way to diagnose and treat these diseased conditions, not caring a pin for the number of cases treated by this one and that one. As far as I am individually concerned, when I run across one of these long-winded, long-worded papers in a medical journal, full of names and dates and statistics, I pass it by and read some paper which tells me what to do. These long-drawn-out,

polished, big-worded articles upon medicine or surgery have no attraction for me. I must admit, however unusual it may be, and however erroneous it may appear, that many of these long, so-called original papers I pass over, and simply read the discussions upon them. The discussions generally contain the meat of the nut. They cover the ground in a condensed and concise manner. We can in this way obtain a knowledge of the papers read by reading a few words in place of reading a great many.

"Discussions of papers are usually limited to five minutes. A great deal can be said in five minutes, provided the one speaking confines himself closely to the subject-matter. But when he speaks one-half of the time in complimenting the speaker, then some time in excuses, he cannot say very much in the two minutes remaining. I think it would be well if the complimentary part was understood, and that no excuse or apologies were made, but let the five minutes be used in actual discussion of the papers.

"About the only criticism I have to make is that our good-natured President did not limit the essayists to twenty minutes and those discussing the papers to five minutes. The trouble, I believe, with many doctors is that they have an idea they will be classed with great men on account of their many words. I think this is a great mistake, for I believe doctors desire always to reach their point of destination by the most direct route they can take, and I believe papers ought to be prepared with that object in view. I know that in my own case in writing I use more words than are necessary. The trouble often is with myself, and no doubt with other doctors, that we have not the time to use few words. The use of few words to express ourselves is generally more difficult and requires far more study than the use of many. It requires far more time to prepare ourselves to say little and mean much than it does to say much and mean little. It may be excusable sometimes to say meaningless things to our patients, although this I do not indorse, but we should not attempt to do so before a learned convention of doctors."

TREATMENT OF SEPTIC CONDITIONS.

Writing on the action of Unguentum Credé (Therap. Monatshefte, October, 1903), Dr. Rommel, of Neuzelle, reports that in a long series of cases his results were satisfactory beyond all expectation. He inuncted the ointment for from fifteen to twenty-five minutes with large, linen-covered corks with rounded edges, the dose for adults and older children being forty-five grains, for small children thirty grains, and for infants under twelve months fifteen grains. The integument was immediately covered with rubber tissue.

The author's results in septic processes entirely agree with those of Dworetzky and others; the ointment has usually a most wonderful effect on acute septic phlegmon, chronic osteomyelitis, erysipelas, puerperal fever, mastitis, and chronic furunculosis. Rommel appends some characteristic

case histories. In articular rheumatism his results also confirm those of other investigators. Cure was at least as rapid as under the salicylate treatment, and large joint effusions disappeared in a surprisingly short time. There is reason to hope that cardiac complications will be less frequent under the silver treatment. Patients who had previous attacks rejoiced that they did not again have to take salicylic acid.

Excellent results were attained in appendicitis when the salve was used before pus formation. Under inunctions of forty-five grains twice daily the fever ceased by the fourth day and the tumor retrogressed unusually rapidly. Similar happy effects were seen in pneumonia. The patients were afebrile on the fourth day after the chill, and simultaneously the pain, bronchial breathing, and dullness quickly diminished. The salve has a marked resorbent effect, especially evident in the pleurisies; in an average time of fourteen days the exudates, many of which were very extensive, partially or entirely disappeared. This encouraged Rommel to try the ointment in old cases with extensive adhesions of the costal and pulmonary pleuræ, so that puncture removed only small quantities of serum, and fever and exudation recurred every few days or weeks. The author believes that absorption was exceptionally rapid; the fever ceased quickly and permanently.

The action of the ointment in influenza was noteworthy. In the usual epidemic there was a whole series of cases in which salipyrin proved useless; complications were expected, but were prevented by Unguentum Credé both this year and last. He always gave two or more further inunctions to prevent recrudescence.

The author found the ointment very useful in tonsillitis and threatened abscess of the glands. A single inunction often caused marked subjective improvement, and two or three further treatments before pus formation cut short beginning tonsilar abscesses.

Rommel had abundant opportunity to observe the action of Unguentum Credé in two large epidemics of scarlatina and measles. The children were treated only with inunction, and the results were surprising. Usually by the fourth, and more rarely only by the fifth, day defebrilization occurred. In cases af scarlatina in which there was a diptheritic exudate, antitoxin was employed besides the inunctions; and in these cases the children got up on the fourth, or latest the sixth, day. None of the measle cases developed otitis media, not even children who formerly had middle ear disease, while this was frequent with cases not treated with the ointment. When earache and reddening of the drum had already begun, all these symptoms disappeared; even cases in which the manifest exudation behind the drum rendered the prospect of paracentesis apparently inevitable escaped the operation. Larger doses twice daily removed pain, fever, and local inflammatory symptoms, and the patients recovered without further treatment. All children complaining of earache in connection with a cold or an attack of influenza should have the inunctions even before there are any objective specular symptoms.

The doses mentioned in the beginning are the smallest from which results can be expected. In severe cases he gives larger and more frequent doses. Thus in pneumonia and puerperal fever he used 1 to 1¼ drams twice daily. Cases in which time has been lost and in which an energetic action is indicated should have Collargolum intravenously.

In the treatment of the fever of consumptives, however, the ointment proved ineffectual.

BIOPLASM is Nature's own tonic and sustainer of the adrenal system. It is something absolutely new in therapeutics. It appeals (see formula inclosed) so directly to the basic cell functions of the system that its therapeutic action is remarkably prompt, and resultant vital incitation is positive and permanent. Bioplasm restores normal tone and power to the sympathetic nervous system by the strictly physiological process of restoring functional capacity.

Bioplasm positively and promptly corrects malassimilation and faulty metabolism, and thereby restores to every form of the cell life of the system the capacity to receive maximum nutrition; hence it is indicated in all conditions involving malnutrition.

PASSIFLORA.—In the functional wrongs of women Daniel's Bonc. Tr. Passiflora Incarnata exerts a remarkable curative influence. It is indicated for all disorders of the female system, such as dysmenorrhea, leucorrhea, and menorrhagia. In acute congestive headache, chronic insomnia, neurasthenia, and nervousness produced from any cause Passiflora acts readily, giving instant relief and inducing healthful sleep, from which the patient awakes refreshed and in possession of his normal faculties. It is unequaled as a sedative, hypnotic, and antispasmodic.

TYREE'S ANTISEPTIC POWDER.—"Invalidism in Girls and Young Women" was recently discussed in a most interesting and instructive way by Dr. W. E. Anthony, of Providence, R. I., ex-President of the Providence Medical Society. Dr. Anthony laid especial stress on guarding girls from overstudy during the first climacteric, recommending that they should not be kept in school more than three or four hours up to the age of seventeen, and suggested that not only were their nervous systems bankrupted by too great burdening during school life, but that their reproductive organs were not permitted to properly develop, and serious diseases and permanent injury of the uterus and ovaries frequently resulted. Dr. Anthony emphasized the fact that these run-down states were often accompanied by vaginal catarrhs most distressing. He recommended for such cases general internal tonics, blood and nerve builders, and the local use of douches daily of a teaspoonful of Tyree's Antiseptic Powder to a pint of warm water, and this treatment has been indorsed by leading practitioners for many years.

TRUE FOOD VALUES.—Under this head the September number of the *Dietetic and Hygienic Gazette* raises a signal that should attract the attention of every physician. It says, among other things: "It is by no means an uncommon thing to find a patient endeavoring, under the advice of his physician, to subsist on some liquid food preparation without the ingestion of a sufficient amount of real food to support the needs of the system." The same article refers to Dr. Harrington's report in the Boston *Medical and Surgical Journal* of March 12, in which he says "that most of the liquid food preparations on the market contain a far larger quantity of alcohol than nutritive material; that the quantity of alcohol by volume ranges from 14 per cent to 23 per cent, as compared with from 6 per cent to 19 per cent in solids; and, therefore, the administration of full doses of those preparations results in the free use of alcohol and in the administration of small quantities of actual nourishment." A good, sound beef diet, then, would appear to offer a maximum of food value, and while there are good grounds for objections to raw meat, a partially digested product should, in our opinion, offer the most desirable form in which beef may be employed. And this is confirmed by experiments that have recently been made by the medical laboratory of the United States army in Washington, under the direction of former Surgeon General Sternberg. This work was carried on for some months, and most exhaustive and careful experiments were made, with the result that Soluble Beef was placed upon the "supply table" of the United States army as representing the maximum of food value in a convenient and concentrated form. The value of Soluble Beef as a food product is generally recognized, and the fact that with it a more nourishing broth may be made than it is possible to make with fresh meat by the usual household methods should recommend it to the busy practitioner and the hospital where the meat press is still used. As Soluble Beef is in a paste form and stable, and may be handled without special knowledge or instructions, it commends itself particularly where the family have to be depended upon to feed the patient. It is a product that is certainly worth careful consideration on the part of every practitioner.

RESOLUTIONS ADOPTED BY THE SOUTHERN MEDICAL COLLEGE ASSOCIATION.

At the last meeting of the Southern Medical College Association, held in Atlanta, Ga., December 14, ult., the following resolutions were adopted:

Resolved: 1. That no ticket or credentials shall be issued by a school belonging to this Association proposing to give credit for a course of medical lectures to a student who has not been in actual attendance and answering roll call for at least 80 per cent of a six months' course, and that no

ticket or credentials shall be accepted as a credit or in advancement which does not show upon its face this evidence of 80 per cent attendance upon each and all courses sought to receive credit for.

2. That in every instance where a student graduates from a school belonging to his Association he or she must have been in actual attendance upon the course immediately preceding the said graduation 80 per cent of six months—except in instances where students have been forced, from sickness or other unavoidable causes, to drop out during their graduating course, in which event the course may be completed in the same school in a subsequent year by attending sufficient time to make up the time lost in the preceding course; or a student failing to graduate in one or more branches may attend a partial subsequent course in the same school, sufficient to pass off such branches. But the degree or diploma can only be awarded at the commencement succeeding such making up of deficient time or branches.

3. That one course of lectures in pharmacy, where the student has simply matriculated and attended in pharmacy and has not matriculated as a medical student, paid fees as a medical student, and pursued all of the studies as a first-year medical student, shall not be entitled to any advancement or credit in medicine by reason of this pharmacy work, and such a student must enter the medical department as though he had had no preliminary study.

4. That where violations of the laws of this Association are reported to the Judicial Committee of the Association it shall be the duty of the said committee to carefully inquire into the facts connected with such charges, after giving the accused college ample opportunity for explanation; and, if found to exist, to report the same with facts and evidence to the Secretary of this Association, who, with the President and Vice President, shall constitute a committee whose duty it shall be to communicate the findings of the Judicial Committee to the State Boards of all Southern States, giving the name of the college and the name and address of the student or students in whose behalf the infractions of law were perpetrated; and these actions shall be taken at once, and before students have been admitted to professional rights in these States.

THE SOUTHERN SURGICAL AND GYNECOLOGICAL ASSOCIATION at its last meeting, held in Atlanta, Ga., December 15-17, elected the following officers for the ensuing year:

President, Floyd W. McRae, Atlanta; First Vice President, George S. Brown, Birmingham, Ala.; Second Vice President, J. Spelton Horsely, Richmond, Va.; Treasurer, Charles M. Rosser, Dallas, Tex.; Secretary, W. D. Haggard, Nashville, Tenn.

Dr. Richard Douglas, of Nashville, and J. Wesley Bovee, of Washington, were named to fill vacancies on the Board of Council.

Birmingham, Ala., was chosen as the place of holding the convention next December.

Two thousand dollars was appropriated for a monument to the late Dr. W. E. B. Davis, one of the founders of the Association and for a number of years its Secretary. The monument will be erected at Birmingham, and will be unveiled at the next meeting.

The last meeting, as were all of its predecessors, was characterized by an unusual amount of most excellent work.

NEW ORLEANS POLYCLINIC.—Seventeenth Annual Session opens November 2, 1903, and closes May 28, 1904.

Physicians will find the Polyclinic an excellent means for posting themselves upon modern progress in all branches of medicine and surgery. The specialists are fully taught, including laboratory work.

For further information address the New Orleans Polyclinic, Post Office Box 797, New Orleans, La.

RHEUMATIC PAIN AND FEVER.—In the *Medical and Surgical Bulletin* we find the following under the caption of "Acute Articular Rheumatism," by Dr. E. G. Evans: "Salol is the best intestinal antiseptic we have, and Antikamnia as a pain reliever is, without doubt, unsurpassed; therefore the combination of these two remedies in the form of the well-known 'Antikamnia and Salol Tablets' affords us the ideal medicament for pain and fever in rheumatic conditions. Patients appreciate the fact that when administering Antikamnia you relieve the pain without giving them morphia, while the Salol acts as a germicide and antiseptic, tending to ameliorate generally the symptoms of the disease. Antikamnia and Salol Tablets (each tablet contains two and a half grains of Antikamnia and two and a half grains of Salol) are best given in doses of two tablets every three hours until ten or twelve tablets are taken during twenty-four hours. The patient's bowels must be kept open and the diet should be light. Alcohol is contraindicated and water should be freely and frequently given. The bed covering should not be too heavy, but warm. Cold water packs, as well as hot fomentations, are very beneficial."

THE TREATMENT OF NASAL CATARRH.—Mannon (*Cincinnati Lancet-Clinic*) finds no danger whatever from the use of the nasal douche, provided ordinary care is taken and a proper solution is employed. The charge that post-nasal douching is prone to excite inflammation of the middle ear, he does not find sustained. All leading specialists employ this method of treatment in the posterior as well as the anterior nares with equally good results. The doctor has had chronic nasal catarrh of many months' duration yield to douching when heroically employed. Listerine to which a small quantity of bicarbonate of soda has been added is his main stand-by. If hemorrhage is a controlling feature, he uses instead a saturated solution of tannic acid, to each ounce of which ten grains of carbolic acid has been added. When the tendency to bleed ceases, he returns to the listerine solution. Treated in this way, the most pronounced cases yield in three or four weeks, and are not prolonged by complications or sequelæ.

GLYCO-HEROIN (SMITH) COMPARED WITH CODEINE AND MORPHINE.—Aside from the after effects of morphine—such as nausea, general lassitude, vomiting, and vertigo—it has the disadvantage that the patient becomes readily addicted to it, and chronic morphinomania occurs, especially in neurotic persons.

Codeine, in its physiologic action, resembles narcotine, though the narcotic stage is not so much pronounced. When administered in small doses intestinal peristalsis is promoted, while in large doses it produces diarrhea in consequence of complete relaxation of the intestinal muscles, owing to paralysis of the nerve centers governing the intestines.

The sedative action of Codeine is unreliable.

Expectoration is not promoted by Morphine or Codeine, while Glyco-Heroin (Smith) acts as a stimulant to the respiratory center, and stagnation of the secretions is excluded.

Comparative doses of Glyco-Heroin (Smith) and Codeine show the latter to produce nausea, vomiting, and vertigo, while these symptoms are absent during the administration of Glyco-Heroin (Smith).

Unlike morphine preparations, Glyco-Heroin (Smith) does not constipate.

Glyco-Heroin (Smith), as a Respiratory Sedative, is decidedly superior to the preparations of opium, morphine, codeine, and other narcotics, as it is devoid of the toxic or depressing effects which characterize the latter when given in doses sufficient to reduce the reflex irritability of the bronchial, tracheal, and laryngeal mucous membranes.

MCFARLAND'S TEXT-BOOK OF PATHOGENIC BACTERIA.—In our notice of this most excellent work in our November, 1903, issue, we neglected to state that it was the *Fourth Edition*, although the notice states that it was a new edition and had been "entirely rewritten."

MEDICAL PRESS EXHIBIT AT ST. LOUIS.—A recent communication from Dr. Charles Wood Fassett, editor of the *Medical Herald,* St. Joseph, Mo., has the following:

"I have secured adequate space at St. Louis, in the palace of Liberal Arts, with a view to making a display of American medical publications which shall be commensurate with the importance of this class of work, and earnestly solicit the coöperation of editors and publishers of medical journals. Decisive action must be taken at once. The expense necessary to make this exhibit will be nominal. There is no charge for space, and I believe that the Department of Publicity will assist us in maintaining an up-to-date and comprehensive exhibit, where files of current issues of every medical journal in the land may be found during the progress of the great fair.

"Full information will be furnished later, and all medical journalists are urged to communicate *at once* with me with a view to united action and early endeavor, so that additional space may be secured, if necessary, to accommodate all who desire to join the bureau."

SEVERE SEPSES SUCCESSFULLY TREATED WITH ENEMATA OF COLLARGOLUM are reported by Dr. H. S. Loebl, of Schlesinger's Division of the Franz-Josef-Spital. During the last two years much therapeutic experimentation has been done in this division with Unguentum Credé and Collargolum. In some cases intravenous injections of the latter were found impossible on account of obesity or smallness of the veins. Collargolum enemata of 2¼ to 4¼ grains in 2½ ounces of distilled water were therefore administered twice daily for eight days, a cleansing enema being given beforehand. Besides two case histories, the speaker demonstrated the temperature curves of three severe sepses, a puerperal infection, and a thrombo-phlebitis following typhoid, in which the favorable results were doubtless due to Collargolum. In four cases the enemata had to be stopped, partly because of negative results, partly on account of other complications. No definite results were obtained in six feverish phthisis cases. The advantages of the enemata lie in their safety and simplicity and in ease with which the dosage may be increased.

In the discussion Dr. Frank highly recommended the intravenous Collargolum injections.

Prof. Hermann Schlesinger agreed with Dr. Frank, holding that Collargolum is a most effective weapon in septic conditions, especially when administered intravenously. Schlesinger has seen apparently hopeless cases saved by it. In his experience the rectal application was just as effective as the intravenous method.

(Abstracted from the Wiener klin. Wochenschrift, October 29, No. 44, 1903.)

Reviews and Book Notices.

THE NEUROLOGICAL PRACTICE OF MEDICINE. A Cursory Course of Selected Lectures in Neurology, Neuriatry, Psychology, and Psychiatry; Applicable to General and Special Practice. With 177 illustrations. After the Author's Class Room Methods as a Teacher of Students. Designed for Students and General Practitioners of Medicine and Surgery. By Charles H. Hughes, M.D., President of the Faculty and Professor of Neurology, Psychiatry, and Electrotherapy, Barnes Medical College. Former Major and Surgeon in Chief of Schofield, Winter, Hickory Street, and McDowell's College Military Hospitals, Superintendent Missouri State Insane Hospital, Acting and Honorary Member of Many Home and Foreign Medical and Scientific Societies, Etc. Member Governing Board of Centenary Hospital, ex-Member Board of Health, and Consultant of City Hospital, Insane Hospital, Etc. 8vo, cloth; 415 pages. Price, $3. Hughes & Co., 418 N. Third Street, St. Louis, Publishers. 1903.

The Neurological Practice of Medicine is a cursory course of selected lectures, from an eminent source of clinical and lecturing experience, on the essential features of neurology, neuriatry, psychology, and psychiatry applicable to the general and special practice of medicine. The book is plainly and forcefully written in the author's well-known, impressive, and succinct style. Many of the pages of the book are peculiarly fascinating and eloquent, as well as accurately descriptive and scientific.

The style of the author in the amphitheater reappears in this remarkable book, as those who have sat under his clear and original teachings will discover in the reading of the several chapters.

The fruitful results of thirty years of extensive clinical experience over a portion of the vast fields of neurology and psychiatry are presented in this valuable book.

The psychiatric factor in surgical and medical practice, psychical depression and the neuropathic diathesis, post-operative insanity, etc., are some of the other and many remarkable features of this remarkable book, from a remarkable source of extensive and broad clinical observation and experience, reaching over a third of a cen-

tury of constant, varied, and wide medical practice, giving aspects of medical observation and reasoning from the neuro-anatomical, neuro-psychological, and neuro- and psycho-therapeutical side of medical observation, that is coming rapidly under the consideration of the profession and destined to prominently prevail in the future practice of medicine.

A REFERENCE HANDBOOK OF THE MEDICAL SCIENCES. Embracing the Entire Range of Scientific and Practical Medicine and Allied Science. By Various Authors. A new edition, completely revised and rewritten. Edited by Albert H. Buck, M.D., of New York. Vol. VII. Illustrated by chromo lithographs and 688 half-tone and wood engravings. Pp. 951. William Wood & Co., Publishers, New York. 1904.

The seventh volume of this magnificent work has just been issued, and in no way falls behind the preceding splendid volumes of this *complete* handbook. The series lacks only one more volume, and will make the most complete work for reference in any of the branches of medicine and surgery extant. This volume begins with "Saccharin" and ends with "Ulcer," among the many important subjects contained being the spinal cord, which is most fully considered in its anatomy, physiology, diseases, and injuries, the article on "Surgery of the Spine," being contributed by our fellow-townsman, Paul F. Eve, M.D., Professor of Surgery and Dean of the Faculty in the Medical Department of the University of Tennessee. His brother, Duncan Eve, M.D., Professor of Surgery in Vanderbilt University Medical Department, also of this city, contributed the article on "Dislocations" in Volume III. The entire work comprises a complete medical library in itself, and is something more than a revision of Beech's "Handbook," nearly all of the articles having been entirely rewritten.

PHYSICIAN'S VISITING LIST (Lindsay and Blakiston's) FOR 1904. Fifty-third year of its publication. Seven different styles, ranging in price from $1 to $2.25. P. Blakiston's Son & Co., Publishers. Sold by all booksellers and druggists.

With this edition "The Physician's Visiting List" enters upon the fifty-third successive year of its publication. This is a record which tells its own story. The old veteran is on hand. In addition to the other valuable features for which it is noted, we wish to

call attention to the pages on incompatibility, chemic, pharmaceutic, and therapeutic, and the page on the immediate treatment of poisoning. "The Physician's Visiting List" is a pocket record book and ever handy reference guide for the medical practitioner. Neat, compact, well-arranged, and durable, it has justly earned so many friends throughout the medical world that commendation is unnecessary.

PROGRESSIVE MEDICINE. A Quarterly Digest of Advances, Discoveries, and Improvements in the Medical and Surgical Sciences. By Hobart Amory Hare, M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College, etc. Assisted by R. M. Landis, M.D., Assistant Physician to the Out Patients' Department of Jefferson Medical College Hospital. Vol. III., December, 1903. 8vo, cloth; 444 pages. Lea Brothers & Co., Publishers. Philadelphia and New York. 1903.

This valuable digest in its concluding volume for 1903—Vol. IV., December—comes to us with all its former excellencies well maintained. The following is a brief summary of its contents: Diseases of the Digestive Tract and Allied Organs, the Liver, Pancreas, and Peritoneum, by John C. Hemmeter, M.D.; Anesthetics, Fractures, Dislocations, Amputations, Surgery of the Extremities, and Orthopœdics, by Joseph C. Bloodgood, M.D.; Genito-Urinary Diseases, by William T. Belfield, M.D.; Diseases of the Kidneys, by John R. Bradford, M.D., F.R.C.P.; Physiology, by A. P. Brubaker, M.D.; Hygiene, by Charles Harrington, M.D.; Practical Therapeutic Referendum, by H. R. M. Landis, M.D. A full and complete index concludes the volume.

THE WORTH OF WORDS. By Ralcy Husted Bell, with an Introduction by Dr. William Colby Cooper. 8vo, cloth; 305 pages. Third Edition, revised and enlarged. Hinds and Noble, Publishers, 31-35 W. Fifteenth Street, New York. 1903. Price, $1.25.

This little work should be in every public and private library, in every school, college, and university. For teachers and writers it is invaluable. It points out the many errors that are so common in speakers and writers. It covers a wide field, and is written by one who has evidently given the subject much and careful thought. The short chapter of about twenty pages, devoted to "Slang," is of more than passing interest. In its previous editions it has received the commendation of able writers and speakers.

MEDICAL RECORD VISITING LIST FOR 1904. William Wood & Co., Publishers, New York.

This "Visiting List" has always given the most complete satisfaction to all who have tried it.

A complete revision of the reading matter in the front part of the "List" has been made this year. The table of average doses has been carefully revised and brought up to date, all the newer drugs of importance being included. A novelty introduced last year for the first time into a "Visiting List" is the Obstetrical Chart. This will be found useful for making quick estimates of the probable duration of pregnancy. In all respects the high standard of manufacture, as to paper, printing, and binding, that has always distinguished the "Medical Record Visiting List" has been fully maintained.

A NONSURGICAL TREATISE ON DISEASES OF THE PROSTATE GLAND AND ADNEXA. By George W. Overall, A.B., M.D., formerly Professor of Physiology in the Memphis Hospital Medical College. 8vo, cloth; 217 pages. Illustrated. Marsh & Grant Co., Publishers, Chicago, Ill., 1903.

In presenting this book to the profession, the author has, by avoiding theoretical discussion, endeavored to give a plain, practical, and concise summary of the methods and results of nonsurgical treatment of diseases of the prostate and their sequelæ as demonstrated by more than twenty years' clinical experience.

Notwithstanding the brilliancy of its sheen and its work in the hands of an experienced surgeon, yet the errors of the knife being so often irreparable gives this little volume a peculiar value. And again it is not always that you can obtain consent for using the knife, and perforce are compelled to resort to other measures.

THE AFTER TREATMENT OF OPERATIONS. A Manual for Practitioners and House Surgeons. By Lockhart Mummey, F.R.C.S., England, B.A., M.B., B.C., Cantab, Demonstrator of Operative Surgery St. George's Hospital, and late Senior House Surgeon of same. 8vo, cloth; 221 pages. Illustrated. William Wood & Co., Publishers, New York. 1903.

The importance of the after treatment is by no means secondary—a most brilliant operation may be rendered ineffectual, and an almost hopeless one may round to under proper measures. The author has given us in this little volume a condensed mass of valuable, practical matter that is to be found in fragmentary form here

and there in the larger text-books on surgery, making it exceedingly useful for reference and study. We can and do most heartily commend it.

MEDICAL NEWS VISITING LIST FOR 1904. Lea Brothers & Co., Philadelphia, Publishers.

This excellent annual publication comes to us with none of its former valuable details omitted. It contains thirty-two pages of data likely to be needed by every practitioner, and blanks for recording all details of practice, both clinical and financial. It is issued in four styles: weekly, dated for thirty patients; monthly, undated, for one hundred and twenty patients per month; perpetual, for thirty patients weekly and sixty patients undated, and without the preliminary data for those requiring specially large record books. The paper, printing, etc., are of the best quality.

Selections.

SALINE INFUSION.—This is the age of revelation. The veil which since the creation has separated the outer from the inner court of nature's great tabernacle is being drawn aside, and the mysteries of the holy of holies are being revealed. Seemingly impenetrable darkness has been pierced by the X-ray, and now the marvelous light of radium is peering still farther into the unknown. The world is learning that the kingdom of heaven is within *us*, and not in some distant realm. Substances which have been considered most simple and common, are found to possess properties of inestimable value. The medical fraternity is following close upon the heels of the scientist and the psychologist; and, beside making discoveries of its own, is reflecting all newly discovered light upon its own profession for the purpose of alleviating human suffering and bringing humanity into harmony with the laws of its creation. The newly discovered properties of "chloride of sodium" are proving to be among the most valuable and efficient agencies of our therapeutical remedies. It has been successfully used in the treatment of numerous diseases, such as habitual constipation, the alleviation of pain by the use of local applications, in

rheumatism, neuralgia, etc., but we wish to consider at this time its newly discovered therapeutical value in the treatment of conditions to which it has previously not been applied. Judging from the increased number of articles we see in our medical journals upon the subject, the use of "saline infusion" is growing in favor with the profession. The three principal ways in which it is administered are: the rectum, hypodermically, and directly into one of the larger veins. The rectum absorbs the solution promptly, and in cases in which the symptoms are not grave this is the proper route to select. From one or two quarts can be given every two hours until the necessary degree of intervascular tension has been reached. In graver cases the solution is administered subcutaneously, infusing from a pint to a quart at a time, and repeating the procedure every hour or two until a sufficient quantity has been used. In *very grave* cases, the intravenous route will yield the quickest and most reliable results. Ordinarily the median basilic vein is selected to receive the solution. It has been demonstrated that a high temperature, not lower than 120° F. is necessary to its highest efficiency, and according to Erkelenz the best results have been obtained not from the true isotonic nine per cent salt solution, but with the six per cent solution. Szuman recommends the addition of carbonate of soda, his "saline solution" being composed of

Sodium chloride.....	6 parts.
Sodium carbonate.....	1 part.
Distilled water.....	1000 parts.

The saline solution is at present most extensively used in diseased conditions associated with either hemorrhage or intense toxæmia. It replaces the fluid lost to the tissues in hemorrhage, and refills the blood vessels, thereby giving the heart something on which to work. It stimulates the cardiac ganglia, sustaining the nutrition of the heart itself, rendering it possible for the remaining blood to be propelled to the vital centers, holding the life forces until new blood can be formed. It relieves collapse, and raises the blood to normal temperature, but its greatest therapeutical power is manifested in lowering the specific gravity of the urine, in exciting diuresis and diaphoresis in all toxic conditions. It also dilutes the poisons circulating in the blood, and by the process of cell-lavage

removes the poison from the paralyzed cell, thereby bringing about a normal function. Permit me to detail a few cases in illustration of of the value of saline infusion:

Case I.—I was called in haste to the bedside of Mrs. W. H. G., about eight miles distant; age thirty-eight, multipara, in the seventh month of pregnancy, with general anasarca from extreme uremia. The fourth convulsion had just passed when I arrived. I administered one-half grain morphine with the usual amount of atropine, hypodermically, and further controlled the convulsions by the rectal administration of hydrate of chloral. I then proceeded to bring on labor as quickly as possible, using hot saline injections against the os uteri, which I think assisted greatly in the dilatation. After delivery the patient had "sinking spells;" the face and hands were cyanotic, the arms and legs were cold, and other symptoms of approaching death were apparent. At this time I used the saline solution by enteroclysis, about a quart at a time, every two hours. The effect was wonderful. The pulse could soon be detected at the wrist, cyanosis disappeared, respiration became regular, consciousness returned. The kidneys responded nicely to the action of the saline infusion, and a surprising quantity of dark colored (almost black) urine was passed in the following twenty-four hours. I am quite confident that I owed the full recovery of this patient to the saline treatment.

Case II.—Dr. F. C., in the *British Medical Journal* of this year, cites a case of a four-year-old boy who had swallowed four ounces of undiluted whisky. Unconsciousness, shallow respiration, with a weak and rapid pulse, supervened in forty-five minutes—the general condition being one of profound collapse. As no vomiting had occurred, the stomach was washed out and the usual stimulation resorted to, without effect. Hot saline enemata were then introduced. The child recovered consciousness within an hour, and was apparently well the next day.

Mercks Archives (April, 1903) reports that a number of cases of bubonic plague were treated with chloride of sodium, the effect of which was to rapidly lower the temperature, the normal being often reached within twenty-four hours, and becoming subnormal three or four days later, and then normal again, under the continued use of this treatment. The buboes diminished in size, and sometimes disappeared. By means of the saline treatment the rate of mortality was reduced fifteen per cent.

In July last two cases of severe sunstroke, in which the regular remedies were entirely ineffectual, were given the saline treatment. The temperature of the two respectively was 108 degrees and 109 degrees F., which ice caps and baths had failed to reduce, and both patients were delirious. At the rate the temperature was maintaining itself, it was a question of only a few hours when they would either become insane or die from exhaustion. It was in this emergency, and with so much at stake, that the saline solution was introduced, an heroic and novel measure. The result was magical. Within an hour one patient regained consciousness, his temperature falling four degrees. In the other case, soon after the infusion, convulsions ceased, and he fell into a deep sleep, with rapidly lowering temperature.

The credit for the first use of the salt solution hypodermically for the cure of pneumonia doubtless belongs to Dr. F. C. Henry, of Philadelphia. Dr. Maurice Kahn records a case of this disease in his practice, where the ordinary methods failed to produce any favorable change in the condition of the patient, who had a pulse of 160, temperature 105 degrees F., Cheynes-Stokes respiration, pronounced cyanosis, cold arms, legs, and forehead, and was apparently moribund. Hypodermoclysis was ventured, four injections, aggregating about three pints, being given within six hours. The immediate effect was astonishing. The pulse became slower and of better quality, the temperature dropped, cyanosis disappeared, respiration became regular, consciousness returned, a general mild perspiration superseded the dry skin, and diuresis was marked. For two days rectal injections of salt solution were given at intervals. The subsequent history of the case is of great interest. On the ninth day of the disease, as there had been no voice sounds nor rales for three days, with absolute dullness of the involved area acupuncture was performed. Result: dry tap. From this time recovery was slow, but on the whole satisfactory.

I have used saline solution in my practice in different ways, in varied diseases, and under varying conditions, with only gratifying results. I would recommend its use for the restoration of blood after hemorrhage from any cause, for shock with or without loss of blood, for collapse in the course of any disease, especially cholera and typhoid fever, or collapse following a surgical operation. In puerperal infections it increases the power of the tissue and blood

to resist the action of microbes, destroys them, and assists nature in throwing off their effects. Its use has also proved beneficial in cases of Epilepsy and of narcotic poisoning.

We have already learned that so simple a substance as our common salt has more in it than has been dreamed of, and its field of usefulness will no doubt be still farther widened and extended.—*H. C. Beckett, M.D., in Virginia Medical Semimonthly.*

THE ORIGIN OF MALIGNANT NEOPLASMS.—F. de Quervain says that experimentation so far has shown that the existence of a parasite of cancer is not yet proved, and that clinical and experimental researches up to the present have only succeeded in establishing the inoculability of cancer by a "cellular graft," and not by a virus, outside living cancer cell. The theory of the parasitic origin of cancer, instead of explaining away all difficulties, gives rise to many new problems which are as difficult to solve as the development of a malignant tumor without the intervention of a microörganism. The search must be continued, but by means of experiments from animal to animal, and not from man to animal. This should be easy enough, because cancer is common in dogs and mice. First of all, one ought to find out whether cancer is transmissible by the cancerous juice, rigorously excluding in these experiments the transplantation of cancer cells. If one could thus discover the vehicle of the virus, it would make it less difficult to determine its nature.—*Medical Press and Circular.*

Prescriptions and Formulary.

Hemorrhages in Typhoid Fever.

G. A. Sheldon, in *Medical Standard,* recommends the following combinations to control the hemorrhages in typhoid fever:

R. Ext. ergotæ flu.....m. x
Morph. sulph.....gr. ¼
Atropinæ sulph.....gr. 1-150
M. Sig.: To be used at one dose hypodermically.

At the same time he administers 15 minims of a solution of adrenalin chlorid (1-1,000), and repeats it in twelve-drop doses every four hours.

As an intestinal antiseptic he recommends sodium sulphocarbolate. After the second week the following combination is given as an antiseptic and to allay as much as possible the tympanitis:

R. Olei terebinthinæ.....℥ii
Olei gaultheriæ.....gr. xii
Pulv. acaciæ.....℥vi
Syr. simplicis.....℥ ss
Aquæ .....℥vi
Misce and filter. Sig.: One dessert-spoonful in a little water every four hours.

To remove the sordes from the teeth and to cleanse the mouth the following is used:

R. Tinct. myrrhæ.....ʒiss
Glycerini .....ʒiii
Succi limonis.....ʒi
Aquæ q. s. ad.....ʒvi

M. Sig.: To be used as a mouth wash.

SWEATING OF THE FEET.

Merck's Archives recommends the following combinations in excessive perspiration of the feet:

R. Acidi salicylici.....gr. xv
Tannoformi .....ʒiss
Pulv. orris.....ʒi
Pulv. talci.....ʒiii

M. Ft. pulvis. Sig.: Apply locally; or

R. Formaldehyde .....ʒiv
Petrolati .....ʒii
Lanolini .....ʒiv

M. Ft. unguentum. Sig.: Apply freely at night; or

R. Pulv. acidi borici.....ʒi
Pulv. amyli.....ʒiii
Tannoformi .....ʒii
Olei caroph.....gtt. i
Olei lavendulæ.....gtt. iii

M. Sig.: Use as a dusting powder.

The following may alternate with the above or supersede it:

R. Ferri glycerophos.....gr. lxxv
Syr. aurantii corticis..... ℥iij
Vini quininæ
Vini kolæ, of each..... ℥vj

M. Sig.: One wineglassful after each meal.

(The wine of kola and of quinine are not standard preparations.)—*Journal of the American Medical Association.*

Whooping Cough.

Dr. J. S. Howard, of Oswego, N. Y., writes to the *Medical Council* of his good results with the following formula:

R. Acidi nitrici dil..... ℥xij
Tinct. card. co..... ℥iij
Syrupi ..... ℥iiss
Aquæ ..... ℥j

Sig.: One or two small teaspoonfuls every two hours.

He has prescribed this remedy to infants before they had any signs of the disease after exposure, with remarkable results. It is in these cases that the remedy is especially valuable.

Cystitis.

There is an advantage, according to the *Journal de Médecine de Paris,* in prescribing salol internally in the form of an emulsion instead of in powder form in the treatment of cystitis. The following formula is recommended:

R. Salol .....gr. xxx-℥j
Pulv. tragacanthæ.....gr. ij
Pulv. acaciæ.....gr. xxx
Tinct. Tolutani..... ℥j
Syr. simplicis..... ℥ss
Aq. destil. q. s. ad..... ℥ij
M. et ft. emulsio.

Sig.: One teaspoonful before each meal.—*Journal of the American Medical Association.*

In axillary bromidrosis the following is recommended:

R. Creolini ..... ʒ i
Ext. violet..... ʒ iv
Alcoholis deod..... ℥iii

M. Sig.: Wash the armpits with warm water, followed by an application of the lotion.

GONORRHEAL EPIDIDYMITIS.

R. Betul-Ol. (Methyl-oleo-salicylate Co.)..... ʒi
Ol. Amygdal. Dulc..... ʒii
Misce fiat applic.

Sig.: Apply to the scrotum on lint and cover with impermeable silk and a suspensory bandage. Change the dressing every two hours. The absorption of the salicylic radical is easily proved by an examination of the urine.

CHRONIC DYSPEPSIA AND PHOSPHATURIA.

R. Syr. Acid. Glycero-phosphatis Comp. (Huxley). ..... ℥viii

Sig.: One teaspoonful diluted with a wineglass of water half an hour before meals, and

R. Acid Arsenosi.....gr. i
Pulv. Ignatiæ.....gr. viii
Pulv. Rhei.....gr. xxxvi
Pulv. Opii.....gr. viii
Misce fiat capsul, No. 60.

Sig.: One capsule immediately following each meal.

CHOREA.

Malbec, in *La Médecine Moderne,* advises the following combinations in the treatment of chorea:

R. Salipyrini ..... ʒ iiss
Strontii brom..... ʒ v
Syr. aurantii corticis..... ʒ ij
Aq. calcis..... ʒ vj

M. Sig.: One teaspoonful in water after each meal.

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